

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05407

CERTIFICATE OF DEATH

05403

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 44 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Md. b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey 02X-2 d. STREET ADDRESS Forest Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Roger O'Neil Akers		4. DATE OF DEATH Month Day Year 5 17 1962					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/32	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md.			
13. FATHER'S NAME Richard Akers			14. MOTHER'S MAIDEN NAME Elizabeth Trapp				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 75-28-2629		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
21. I certify that (I) (this hospital) attended the deceased from 4/3 1962 to 5/17 1962 that (I) (we) last saw the deceased alive on 5/17 1962 and that death occurred at 7:42 M. from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer M.D.				22b. DATE SIGNED 3/17/62			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			
				23d. LOCATION (City, town or county) (State) Elkridge Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons				25. REC'D BY REGISTRAR DATE MAY 21 '62			
				25b. REGISTRAR'S SIGNATURE C. H. H. H.			

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

737

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05408 CERTIFICATE OF DEATH 05404										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2519 Wendover Rd</u>					d. STREET ADDRESS <u>2519 Wendover Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Ethelinda</u> Last <u>Allen</u>					4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-29-99</u>		9. AGE (In years last birthday) <u>63</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Sport Service</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>George Washington Russell</u>					14. MOTHER'S MAIDEN NAME <u>Ida May Myers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>28-07-4399A</u>					17. INFORMANT <u>Mr John D Allen - 1438 Langford Rd.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (his hospital) attended the deceased from <u>May 1962</u> to <u>May 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>May 20, 1962</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>R Donald Jandorf</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>5-22-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>					22d. ADDRESS <u>607 N Harford Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-28-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto Nat'l Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J Jickew</u>					ADDRESS <u>Balto 12, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 28 62</u>		25b. REGISTRAR'S SIGNATURE <u>Wm J Jickew</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05409

CERTIFICATE OF DEATH

05405

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 50 E. 26th Street i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT T. ALLINSON		4. DATE OF DEATH Month May Day 1 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12, 1898
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert T. Allinson	
14. MOTHER'S MAIDEN NAME Nettie Strong		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 218-07-0182		17. INFORMANT Clinical Records, VA Hospital Fort Howard, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA ANTRUM OF STOMACH WITH REGIONAL LYMPH NODE METASTASIS AND PERITONEAL CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). CIRRHOSIS OF LIVER, CHOLECYSTITIS AND CHOLELITHIASIS. MYOCARDIAL FIBROSIS INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 28 , 19 62 to May 1 , 19 62 , that (X) (we) last saw the deceased alive on May 1 , 19 62 , and that death occurred at 5:50AM , from the causes and on the date stated above.			
22a. SIGNATURE Sebastian Russo M.D.		22b. DATE SIGNED 5/1/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1962	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Zokor ADDRESS Balt 17, Md.		25a. REC'D BY REGISTRAR DATE MAY 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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James H. [Signature]

RECEIVED

1 FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05410											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				d. STREET ADDRESS <u>37 Hiltshire Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Riverside Drive. Balto. 21</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERICK CARMEN AMOROSO</u>						4. DATE OF DEATH Month Day Year <u>MAY-9-62</u> 19 <u>62</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-45</u>		9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred Amoroso</u>						14. MOTHER'S MAIDEN NAME <u>Eleanor Bonkowski</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Parents (Same as above)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING -</u> <u>891.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Overcome by Gas while parked in Auto</u>							
20c. TIME OF INJURY Month, Day, Year <u>7th</u> a.m. <u>5-9-62</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Public Inn</u>		20f. City or town <u>Essex-21-Balto</u>		20g. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>M.B. Davis</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>5/10/62</u>					
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-12-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or country) <u>Balto.</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR <u>John J. Connelly 418 Eastern Blvd. (21)</u>						24a. REC'D BY REGISTRAR <u>MAY 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krass</u>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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DEATH REG.
-FOR STATE-

(M)

(C)

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(G)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05411

05407

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN lb <u>12 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Gorsuch Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>14 Gorsuch Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Pyle Amos</u> First Middle Last 4. DATE OF DEATH <u>May 25, 1962</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 21, 1923</u> 9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Recreation</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Pyle</u> 14. MOTHER'S MAIDEN NAME <u>Hester Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>21220-7007</u> 17. INFORMANT <u>Leonard T. Amos, 14 Gorsuch Rd., Md. Timonium</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>14y pertussis</u> DUE TO <u>3 yrs</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>May 25 1962</u> that (I) (we) last saw the deceased alive on <u>May 23 1962</u> and that death occurred <u>4:00 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Milner Bortner</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>MILNER BORTNER</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22d. ADDRESS <u>WHITE HALL, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 28, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Deob. Harlunstein, New Freedom, Pa.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>Arthur S. Harts</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harts</u> DATE <u>MAY 29 '62</u>	

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05412

05408

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1535 Rosewick Avenue		d. STREET ADDRESS 1535 Rosewick Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRDERICK Middle AROLD Last AROLD		4. DATE OF DEATH Month MAY Day 24 Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1879
9. AGE (In years less birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Arold		14. MOTHER'S MAIDEN NAME Margaret Ritter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Wallace R. Arold, 1535 Rosewick Avenue, Zone 6		Address V	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 433.0 DUE TO ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 90A	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that N (this hospital) attended the deceased from Dec 19, 1959 to Dec 19, 1959 , that (I) (we) last saw the deceased alive on Dec 19, 1959 , and that death occurred at 10AM , from the causes and on the date stated above.			
22a. SIGNATURE Dr John Geldrich M.D.		22b. DATE SIGNED May 25, 1962	
22c. PHYSICIAN'S NAME (Type) John Geldrich, M.D.		22d. ADDRESS 8019 Philadelphia Road #6	
23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		23b. DATE THEREOF 5-26-62	
23c. NAME OF CEMETERY OR CREMATORY Sater's Baptist Cemetery		23d. LOCATION (City, town, or county) (State) Falls Road, Baltimore County	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, 1050 York Road, TOWSON 4, Md		25a. REC'D BY REGISTRAR MAY 28 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Thomas			

Caroline Abbott

5712

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05409

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 90 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nurs.Home.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 720 Brookwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank E. Badart		4. DATE OF DEATH Month May Day 31, Year 19 62	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jun. 1, 1881
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank A. Badart		14. MOTHER'S MAIDEN NAME Louise Daborne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 05 9667	
17. INFORMANT Mr. Frank A. Badart		Address 1300 Ridge Rd, Catonsvi	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOMA (GENERALIZED) 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC DISEASES DUE TO (c) PULMONARY EDEMA - CIRCUMSTANTIAL PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/2 1962 to 5/31 1962 that (I) (we) last saw the deceased alive on 5/31 1962, and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE John H. Sigaw		22b. DATE SIGNED 6/1/62	
22c. PHYSICIAN'S NAME (Type) JOHN H. SIGAW M.D.		22d. ADDRESS 5801 EDMONDSON AVE, BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF 6/2/62	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum Woodlawn Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave		25a. REC'D BY REGISTRAR DATE JUN 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur E. Haines			

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Baltimore

Catonville

Shady Wood Trus. Home.

Frank

H.

W.

M.

Retired

Frank A. Bagart

Balto. Transit Co.

England

Louise Bagart

113 OS 8607 Mr. Frank A. Bagart, 1300 Ridge St, Catonsville

*Frank A. Bagart (Catonville)
1300 Ridge St, Catonsville
Baltimore, Md.*

Residence 4/2/53

Frank A. Bagart, 1300 Ridge St

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05414

054110

1. PLACE OF DEATH e. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>TOWSON CON VALESCENT HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X TOWSON</u> d. STREET ADDRESS <u>603 E. JOPPA RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>NELSON</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1962</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 27, 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL ENG. RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BLACK & DECKER</u>				11. BIRTHPLACE (County & State, or foreign country) <u>OWEGO, NEW YORK</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JAMES RUSSELL BAKER</u>						14. MOTHER'S MAIDEN NAME <u>ISABELL DECKER</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-10-9492</u>				17. INFORMANT Address <u>FAMILY RECORDS</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL INFARCTION FROM EMBOLUS</u> 42010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PAROXYSMAL AURICULAR FIBRILLATION</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>												INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>11 yrs</u> <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>BRONCHIAL ASTHMA; URINARY TRACT INFECTION</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/26, 1951</u> to <u>5/4, 1962</u> that (I) (we) last saw the deceased alive on <u>4/26, 1962</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Donald L. Somerville</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5/5/62</u>									
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE</u>						22d. ADDRESS <u>25 WPA AVE; TOWSON 9, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>				23b. DATE THEREOF <u>5/4/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. CITY</u>				23d. LOCATION (City, town or county) (State) <u>MD. STATE ANATOMICAL BOARD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Son's</u> ADDRESS <u>Towson</u>															
25a. REC'D BY REGISTRAR <u>MAY 8 '62</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The fee 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
054115 CERTIFICATE OF DEATH 05411

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN b 20 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Res., 2523 West Woodwell Rd.		d. STREET ADDRESS 2523 W. Woodwell Rd.	
3. NAME OF DECEASED (Type or print) LAURA First ELLIS Middle BALL Last		4. DATE OF DEATH Month May Day 16. Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sent. 14, 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 16 Hours 16 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mc Million		14. MOTHER'S MAIDEN NAME Hanora Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mazie Sizemore		Address 2523 W. Woodwell Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertension (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 19, 1940 to May 16, 1962 , that (I) (we) last saw the deceased alive on May 16, 1962 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Morris A. Jacobs		22b. DATE SIGNED 5/17/62	
22c. PHYSICIAN'S NAME (Type) Morris A. Jacobs		22d. ADDRESS 1010 North Pt. Road Balt 22, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 18, 1962	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION (City, town or county) (State) Trumms Mill Rd., Md.
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		25a. REC'D BY REGISTRAR MAY 22 '62	
ADDRESS 7922 Wise Ave. 22. Md.		25b. REGISTRAR'S SIGNATURE Ciribing S. Kimes	

11430

11430



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05416 CERTIFICATE OF DEATH 05412

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville		d. STREET ADDRESS Rt. 2 Box 28	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Virgel Beall				4. DATE OF DEATH Month Day Year May 12 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1919	
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Tobacco		10b. KIND OF BUSINESS OR INDUSTRY Tenent Farm		11. BIRTHPLACE (County & State, or foreign country) Hall, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S. A.				13. FATHER'S NAME John Franklin Beall			
14. MOTHER'S MAIDEN NAME Martha Tayman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			
16. SOCIAL SECURITY NO. 217-28-8151				17. INFORMANT Address Mrs. Mary Smith, sister, Glendale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 6, 1962 , to May 12, 1962 , that (I) (we) last saw the deceased alive on May 12, 1962 , and that death occurred at 10 a.m. from the causes and on the date stated above.							
22a. SIGNATURE H. I. Cholmondeley				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 12, 1962	
22c. PHYSICIAN'S NAME (Type) H. I. Cholmondeley				22d. ADDRESS Spring Grove State Hosp. Catonsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/62		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Cemetery		23d. LOCATION (City, town or county) (State) Annapolis Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro,				ADDRESS Md.		25a. REC'D BY REGISTRAR MAY 16 '62	
				25b. REGISTRAR'S SIGNATURE Carroll S. Francis			

05512

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R.T.C.

April

Apr. 18, 1911

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Ball,

Mr. W. L. Ball

Ball,

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Mr. W. L. Ball

Mr. W. L. Ball

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Mr. W. L. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, rited in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, end in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05417
CERTIFICATE OF DEATH
06656

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Valley Rd., Stevenson, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helena Middle Leith Last Beall		4. DATE OF DEATH Month May Day 8 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1942
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William D. Beall		14. MOTHER'S MAIDEN NAME Helena L. Dohoney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm.D. Beall, Valley Rd., Stevenson, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hodgkins Disease } (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 to May 8, 1962 that (I) (we) last saw the deceased alive on May 8, 1962 and that death occurred at 8 AM , from the causes and on the date stated above.			
22a. SIGNATURE Paul H Royse M.D.		22b. DATE SIGNED 9 May 62	
22c. PHYSICIAN'S NAME (Type) Paul H Royse MD		22d. ADDRESS 1403 Foley Lz. Pikesville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 11, 1962	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville 8, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		25a. REC'D BY REGISTRAR DATE JUN 12 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05418
05413

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville Rural</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Maryland Masonic Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>_____</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1522 Hanover ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amelia Elizabeth Beck</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Balto, City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William F Sopp</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Scipp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Masonic Home Records Cockeysville Md</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic atherosclerosis - renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rt. breast lump - probably malignant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>61</u> , to <u>May</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 29</u> 19 <u>62</u> , and that death occurred at <u>6:01</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Scherrell</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Scherrell MD</u>		22b. DATE SIGNED <u>5/30/62</u>	
22d. ADDRESS <u>Cockeysville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-2-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>		25a. REC'D BY REGISTRAR <u>4 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Deputy Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return any event within 72 hours after death.

VR A15ME
SM 1/62

05419

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05414

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md b. COUNTY Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 421 Academy Road			d. STREET ADDRESS 421 Academy Road		
3. NAME OF DECEASED (Type or print) Mary E. Blickenstaff			4. DATE OF DEATH May 23, 1962		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1912		9. AGE (In years last birthday) 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home Duties		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME F Nelson Elliott			14. MOTHER'S MAIDEN NAME Viola C. Eldridge		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give year or dates of service)			16. SOCIAL SECURITY NO. H. Ronald Blickenstaff		
17. INFORMANT H. Ronald Blickenstaff			Address 421 Academy Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by placing a plastic bag over her 974X DUE TO Conditions, if any, which gave rise to immediate cause (b) head also pillow over bag (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Geo. S. M. Kieffer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 23, 1962			
Address (Street, city, town, or county) 1010 Leeds Ave 29					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-62		22c. NAME OF CEMETERY OR CREMATORY ROSE Hill Cemetery	
22d. LOCATION (City, town, or country) Hagerstown, Md.					
23. FUNERAL DIRECTOR Wm J. Zickner		ADDRESS Baltimore, Md		24a. DEC'D BY REGISTRAR MAY 28 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kieffer					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
05420					05415				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Baltimore</u>		MARYLAND			a. STATE <u>Maryland</u>		b. COUNTY <u>-</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				<u>3 VAL-4</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holly Hill Nursing Home</u>				d. STREET ADDRESS <u>Broadview Apts.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <u>Bowie</u>		Middle <u>Griffith</u>		Last <u>Blount</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>19 62</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1870</u>		9. AGE (In years last birthday) <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Richard Griffith</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Palmer</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Charles Anderson</u> Address <u>7523 Club Road Ruxton, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from <u>4/20</u> 19 <u>62</u> to <u>5/21</u> 19 <u>62</u> that (I) two last saw the deceased alive on <u>5/21</u> 19 <u>62</u> and that death occurred at <u>11/2</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W. Meredith Smith</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/21/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. M. Smith</u>				22d. ADDRESS <u>6305 The Atlantic - 12</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5/21/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co. Baltimore 12, Maryland</u> ADDRESS <u>4905 York Road</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 24 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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1050

DEATH CASE OF DEATH

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CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2906 Pennsylvania Avenue					d. STREET ADDRESS 2906 Pennsylvania Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOLLIE Middle C. Last BOSMAN					4. DATE OF DEATH Month May Day 29 Year 19 62				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1894		9. AGE (In years last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Uric Blockinger					14. MOTHER'S MAIDEN NAME Mary Dergartner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Miss Lillian Bosman, 2906 Pennsylvania Ave, Zone 27				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 19 62 to May 29 19 62 that (I) (we) last saw the deceased alive on May 27 19 62 , and that death occurred at 11 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Paul Schonfeld					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6/1/62	
22c. PHYSICIAN'S NAME (Type) Paul Schonfeld, M.D.					22d. ADDRESS 2301 Annapolis Road				
23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL			23b. DATE THEREOF 6-2-62		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2 ADDRESS						25a. REC'D BY REGISTRAR JUN 1 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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CHARTER OF DATE

1832

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General Order
No. 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05422
05417

Item 23b Film 0313 5/28/62 mh

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u> c. LENGTH OF STAY IN 1b <u>114 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9921 REISTERSTOWN BL.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u> d. STREET ADDRESS <u>9921 REISTERSTOWN</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY</u> <u>HARCOURT OWINGS</u> <u>BOWEN</u>		4. DATE OF DEATH Month Day Year <u>MAY</u> <u>16</u> <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 25-1872</u>
9. AGE (In years last birthday) <u>89 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE (Organist)</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Mansfield B. Harcourt</u>	
14. MOTHER'S MAIDEN NAME <u>Florence Mae Adams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Florence Adams Bowen - 9921 Reisterstown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 331X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Arteriosclerosis - generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1962</u> to <u>May 16, 1962</u> and that (I) (we) last saw the deceased alive on <u>May 16, 1962</u> and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles E. McWilliams</u> M.D.		22b. DATE SIGNED <u>May 16 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Reisterstown</u>		22d. ADDRESS <u>Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>May 19, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Jr.</u> ADDRESS <u>Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 18 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

03317

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(1)

Robert Threlkeld (Scott)
Pittsburgh, Pa.

George E. McWilliam
Pittsburgh, Pa.

Stacy H. McWilliam
Pittsburgh, Pa.

CERTIFICATE OF DEATH

05418

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Res., 1 Denton Ave. 19, Md.</u>				d. STREET ADDRESS <u>1 Denton Ave. 19, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD J. BOWERS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1909</u>	9. AGE (In years and birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heater</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Minnie A. Aspelmeier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-5723</u>		17. INFORMANT Address <u>Mrs. Georgia Bowers Same as 4 D</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Coronary arteriosclerosis</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hr.</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u>May 26</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 10 19 62</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John V. Conway</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John V. Conway M.D.</u>				22d. ADDRESS <u>914 D Street. 19. Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-29-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Taylor Ave. 14, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u>				ADDRESS <u>7922 Wise Ave. 22. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 28 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur J. Harris</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05419

1. PLACE OF DEATH e. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES 16 FUSTING AVE.		d. STREET ADDRESS 624 WILDWOOD PKWY.	
3. NAME OF DECEASED (Type or print) First EDNA Middle V. Last BROWN		4. DATE OF DEATH Month MAY Day 5 Year 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9, 1889
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months - Days -	11. IF UNDER 24 HRS. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPANION		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME HARRY A. BROWN		14. MOTHER'S MAIDEN NAME ALICE E. FLANNERY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 216-01-5583	
17. INFORMANT Address MRS. MOULIE I. BROWN, 624 WILDWOOD PKWY.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Carcinomatosis 170X DUE TO Carcinoma of the breast Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO - (c) -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. - p.m. -		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1961 to May 5, 1962 , that (I) (we) last saw the deceased alive on May 5, 1962 , and that death occurred at 6:05 P.M. the causes and on the date stated above.			
22a. SIGNATURE George A. Knipp M.D.		22b. DATE SIGNED May 7 1962	
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M.D.		22d. ADDRESS 4116 Edmondson Ave. #29	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/9/62	
23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town or county) (State) WOODLAWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE		25a. REC'D BY REGISTRAR MAY 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE MAY 8 '62	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05425

05420

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reisterstown Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS Reisterstown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Agnes Brown				4. DATE OF DEATH Month Day Year May 24, 1962 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1908	
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed at Convelesent Home				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Towson, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Alice Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-34-3805		17. INFORMANT Harold L. Allgeyer, Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aricular Fibrillation 416 X } DUE TO Rheumatic Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a.m. p.m. none		20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 26, 1962		22c. NAME OF CEMETERY OR CREMATORY New Cathedral	
23. FUNERAL DIRECTOR J.F.Eline & Sons, Reisterstown, Md.				22d. LOCATION (City, town, or country) (State) Baltimore, Md.		24a. REC'D BY REGISTRAR MAY 28 '62	
24b. REGISTRAR'S SIGNATURE							

05-21

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1902



Baltimore

Baltimore

Baltimore

Baltimore

Baltimore Road

Baltimore Road

May 24, 1902

John Brown

April 20, 1902

John Brown

Town, Maryland

John Brown

John Brown

John Brown

John Brown, Baltimore, Md.

May 26, 1902

John Brown, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05421

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY d. STREET ADDRESS RD 2, JERSEY ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Bryant		4. DATE OF DEATH Month May Day 6 Year 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1892
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 22 Days X	IF UNDER 24 HRS. Hours 2 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Fertilizer Plant	11. BIRTHPLACE (County & State, or foreign country) Southampton Co. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Bryant	
14. MOTHER'S MAIDEN NAME Mary (Last Name Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 219-07-7650		17. INFORMANT Clinical Records Folder, Veterans Administration Hospital, Fort Howard, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION DUE TO 465X Conditions, if any, which gave rise to immediate cause (b) 465X (c) 465X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION. ARTERIO-NEPHROSCLEROSIS, HYPERTROPHY THYROID GLAND		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury (County) Wicomico (State) MD		21. I certify that (1) (this hospital) attended the deceased from April 13, 19 62 to May 6, 19 62 , that (X) (we) last saw the deceased alive on May 6, 19 62 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Sebastian Russo M.D. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5/7/62 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/1962	
23c. NAME OF CEMETERY OR CREMATORY Green acres		23d. LOCATION (City, town or county) Salisbury (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart ADDRESS Salisbury MD		25a. REC'D BY REGISTRAR MAY 14 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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15461

NO. 2, LEBERT ROAD

VICTIM'S LAST KNOWN LOCATION

Perkins Road, Sonoma Co., California, U.S.A.

Time between

Mary (last name unknown)

Edward Higgins

Clinton Heights, Sonoma, California
1. Lincoln and Higgins, San Francisco, California

219-01-1020

W I

Yes

UNKNOWN LOCATION

NO. 2, LEBERT ROAD, VICTIM'S LAST KNOWN LOCATION

THE, FOX, HOUND, HOUND

DELAWARE HOUND, N. D.

Prints 1110

05422

05427

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODCRAFT</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8906 Edgefield Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph W Buchanan</u>		4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13 1920</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cas & Elec Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO MD</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WII</u>		16. SOCIAL SECURITY NO. <u>214-18-7696</u>	
17. INFORMANT <u>Mary Buchanan</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease 3+ yrs</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>59</u> , to <u>May</u> , 19 <u>62</u> , that I lost s/he the deceased alive on <u>May 28</u> , 19 <u>62</u> , and that death occurred at <u>4:35</u> P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7005 HARFORD Rd BALTO 34 MD</u> DATE SIGNED <u>5/31/62</u>	
ACTUAL SIGNATURE <u>Frank P. Kasik Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>F. T. Kasik Jr.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 1 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans & Son</u>		ADDRESS <u>8802 HARFORD Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 1 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Thomas</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

(M)

(L)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05428
05423
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4241 Silver Spring Road</u>			d. STREET ADDRESS <u>4241 Silver Spring Road</u>		
3. NAME OF DECEASED (Type or print) <u>Mr. Andrew Miles Burton</u>			4. DATE OF DEATH Month <u>May</u> Day <u>17th</u> Year <u>62</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1885</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Maintenance Man</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edward Burton</u>		
14. MOTHER'S MAIDEN NAME <u>Ann Simms</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		
16. SOCIAL SECURITY NO. <u>212 16 9612</u>			17. INFORMANT <u>Mrs. Mary J. Burton</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)			(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1962</u> to <u>May 17, 1962</u> ; that (I) (we) last saw the deceased alive on <u>May 16, 1962</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Theodore E. Evans</u>			22b. DATE SIGNED <u>5/17/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Theodore E. Evans</u>			22d. ADDRESS <u>Perry Hall Medical Center</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/21/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc</u>			25a. REC'D BY REGISTRAR <u>MAY 21 '62</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

00000

STATE OF TEXAS

1900

(M)

212 1622

(1)

5/21/02

Recorded in Vol. 200, Page 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
05429

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05424

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7mthl1dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPI TAL		d. STREET ADDRESS 747 S.Woodington Road	
3. NAME OF DECEASED (Type or print) First Mary Middle B. Last Carroll		4. DATE OF DEATH Month May Day 26 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1878
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factory worker		10b. KIND OF BUSINESS OR INDUSTRY Brush buffer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Isaac Bewley		14. MOTHER'S MAIDEN NAME unknown Margaret Catherine Kaiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 213-05-2914	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Decubiti ulcers		INTERVAL BETWEEN ONSET AND DEATH from 4-10-62 for years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 19 19 61 , to 19 , that (I) (we) last saw the deceased alive on 9-19 19 61 , and that death occurred at 9 M, from the causes and on the date stated above.			
22a. SIGNATURE D. Inne Kopits M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D. Inne KOPITS		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1962	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR MAY 29 '62	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

CERTIFICATE OF DEATH

1928

May 26, 1928

Death of

James M. McPherson

Resident of Baltimore, Md.
New Catholic Cemetery
May 29, 1928
Cottsville, Md.

FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4813 Kenwood Avenue					d. STREET ADDRESS 25 Leslie Avenue					
3. NAME OF DECEASED (Type or print) First THELMA Middle ELIZABETH Last CASSEDY					4. DATE OF DEATH Month May Day 21 Year 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-16-1913		9. AGE (In years last birthday) 49 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) BALTO., MD.			12. CITIZEN OF WHAT COUNTRY? U-S-A.			
13. FATHER'S NAME CHARLES SCHEMMEL					14. MOTHER'S MAIDEN NAME EDNA McCLELLAND					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-6937		17. INFORMANT Address EARL CASSEDY 25 LESLIE AVE						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebellar hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Arteriosclerotic cardiovascular disease										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE R. Breitenecker					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R. Breitenecker, M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 5-25-62		22c. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH		22d. LOCATION (City, town, or country) (State) BALTO MD.	
23. FUNERAL DIRECTOR Lorahy Fun & Hous 7401 Belair Rd					24a. REC'D BY REGISTRAR MAY 24 '62		24b. REGISTRAR'S SIGNATURE Charles S. Harris			

00452

1430

LIFE

7-2-1913

0-2-B

DAIRY MO.

HOME

BRUSWITE

EDNA McLELAND

ROBERT SCHEMME

22-4-131

BOAL CONDOY 22 RESID 143

NO

EDNA MO.

7-2-131 1430

00452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 1010 Warwick Avenue	
3. NAME OF DECEASED (Type or print) Edgar A. Cassell		4. DATE OF DEATH Month May Day 7 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1892
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin H. Cassell		14. MOTHER'S MAIDEN NAME Melinda Frye	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-05-4563	
17. INFORMANT Clinical Records, V. A. Hospital		Address Fort Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA BILATERAL 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CIRRHOSIS OF LIVER DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 9, 1962 to May 7, 1962 , that (X) (we) last saw the deceased alive on May 7, 1962 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Sebastian Russo M.D.	
22b. DATE SIGNED 5/7/62		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND		22e. REC'D BY REGISTRAR DATE MAY 10 '62	
22f. REGISTRAR'S SIGNATURE Arthur S. Krum		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 5/10/62		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	
23d. LOCATION (City, town or county) (State) BALTO. MD.		24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.	

1001

John Brown

no date

Thomas Administration Hospital

Right

X

July 15, 1902

Left

Conservation

Belmont, Maryland

U.S.A.

John H. O'Connell

Belmont, Maryland

John H. O'Connell, N. A. Hospital

July 15, 1902

July 15, 1902

John H. O'Connell, N. A. Hospital

Belmont, Maryland

Left

Belmont, Maryland

Left

John H. O'Connell

Belmont, Maryland

John H. O'Connell, N. A. Hospital

John H. O'Connell, N. A. Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05432

05427

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 48 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM T. CHACHULSKI		4. DATE OF DEATH Month May Day 2 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 8, 1921
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Pictures	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Chachulski		14. MOTHER'S MAIDEN NAME Tillie Kordonski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11 214-26-9611	
17. INFORMANT Clinical Records, VAH, Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 157 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) CARCINOMA, PANCREAS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Operation: (VAH DUBLIN, GA) CA OF PANCREAS, METASTATIC TO LIVER, Oct 1961			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15, 19 62 to May 2, 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 2, 19 62 , and that death occurred at 1:35 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman, M.D.		22b. DATE SIGNED 5/2/62	
22c. PHYSICIAN'S NAME (Type) Irving Freeman, M.D.		22d. ADDRESS VAH FORT HOWARD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-5-1962	
23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY		23d. LOCATION (City, town or county) (State) BALTIMORE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Kaczorowski		25a. REC'D BY REGISTRAR MAY 7 '62	
ADDRESS 2525 FLEET ST.		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

STATE OF CALIFORNIA

1983

M

1

Obituary: (VAN DUREN, CA) CA OF PANCREAS, METASTASIS TO LIVER, OCT 1981

Living Person, M.D.

CANCER, PANCREAS

CANCER, PANCREAS

Unknown

Unknown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05433

05428

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami Beach 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home		d. STREET ADDRESS 928 Ocean Drive	
3. NAME OF DECEASED (Type or print) First RHODA Middle CHERTOK Last (CHESTER)		DATE OF DEATH Month MAY Day 14 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 1891
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Paperman		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT DAVID CHESTER		Address 7939 Winterset Ave Zone 8	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Artemia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Arteriosclerotic Cardiovascular Disease (c) Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 to 19 , that (I) (we) last saw the deceased alive on 5/14/1962 and that death occurred at 12:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Leonard Golombek		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Leonard Golombek		22d. ADDRESS Woodmoor Shopping Center, Liberty Rds.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/15/62	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Young Men		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC 6010 Reist Rd.		25a. REC'D BY REGISTRAR MAY 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DEATH CERTIFICATE

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DATE OF DEATH
PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Carney c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3032 East Avenue				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Carney d. STREET ADDRESS 3032 East Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) AGNES				First AGNES Middle CHLUMSKY Last CHLUMSKY				4. DATE OF DEATH Month May Day 16 Year 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/24/85		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Bourek				14. MOTHER'S MAIDEN NAME Anna Chlumsky									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)				17. INFORMANT Address Anthony Chlumsky, son, 3524 Kentucky Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac Arrest (Stokes Adams) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Myocardial degeneration and early C.H.F.; Arteriosclerosis (b) Sudden DUE TO 3-wks. (c) 3.5 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) Carney, Md.	
21. I certify that (I) (this hospital) attended the deceased from May 18, 1962 to May 18, 1962 , that (I) (we) last saw the deceased alive on May 18, 1962 , and that death occurred at 7:30 P.M. from the cause and on the date stated above.													
22a. SIGNATURE Frank T. Kasik Jr.				22b. DATE SIGNED 5/17/62				22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS 9005 Harford Rd (34) Md.	
22e. PHYSICIAN'S NAME (Type) FRANK T KASIK JR.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/21/62				23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery				23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimuek				24a. ADDRESS Funeral Home 3331 Brehms Lane				25a. REC'D BY REGISTRAR MAY 21 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Pinner	

(M)

Baltimore

Carney

3032 East Avenue

ADAMS

CHILSKY

May 10

3032 East Avenue

Carney

Md.

female white

5/26/32

77

housewife

at home

Czechoslovakia

U.S.A.

Anton Borek

Anna Chilsky

Anthony Chilsky, son, 3234 Kentucky Ave.

Handwritten notes:
The following information was obtained from the records of the Baltimore City Department of Health and Sanitation, dated 5/26/32.
The following information was obtained from the records of the Baltimore City Department of Health and Sanitation, dated 5/26/32.
The following information was obtained from the records of the Baltimore City Department of Health and Sanitation, dated 5/26/32.

Box 141 5/21/32 Holy Redeemer Cemetery Baltimore, Md.

Charles E. Schimmon Funeral Home
3331 Stearns Lane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05435

CERTIFICATE OF DEATH

05430

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> for years <u>1</u> d. STREET ADDRESS <u>301 S. Rolling Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Died at her residence</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET PONTIUS COBLENTZ.</u>		4. DATE OF DEATH <u>May 17 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-7-1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Meadville, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rev. John W. Pontius</u>		14. MOTHER'S MAIDEN NAME <u>Ida Apple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Edw. P. Coblentz (son)</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Embolus</u> (a), stating the underlying cause last. } DUE TO <u>Generalized Arterio Sclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>46 hrs</u> <u>4 days</u> <u>59 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> 19 <u>35</u> to <u>May 17</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 17</u> 19 <u>62</u> , and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Sherford -</u>		22b. DATE SIGNED <u>May 17 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Sherford -</u>		22d. ADDRESS <u>7115 West</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>May-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Church Cem.</u>	23d. LOCATION (City, town or county) <u>Middletown, Maryland.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Mowen Co.</u>		25a. REC'D BY REGISTRAR <u>May 21 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05437

CERTIFICATE OF DEATH

05432

Item 14 Film G312 5/15/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN lb <u>19 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto city</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>Baltimore 70</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alice Bacon Conrad</u> First Middle Last 4. DATE OF DEATH <u>May 8 1962</u> Month Day Year			5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 4, 1867</u> 9. AGE (In years, last birthday) <u>94 1/2</u> yrs Months Days IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife-retired</u> 13. FATHER'S NAME <u>JAMES MCCAIN</u>			10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>MEMPHIS, TENN.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH McCain</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>W. GEORGE SCARLETT 917 Poplar Hill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis Heart Disease</u> (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis about 2 weeks ago</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-11-62</u> 19 <u>62</u> to <u>5-8</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 4</u> 19 <u>62</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.						
22a. SIGNATURE <u>P. Kaye Low</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>9 May 8-62</u>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1632 Kearsley Ave Rd. Pikesville 8, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u>		
23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHN O. MITCHELL & SONS, INC 1900 EUTAW PL.</u>				
25a. REC'D BY REGISTRAR <u>MAY 10 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				

10482

10482

James Mc Cain
W. George Schaefer
Elizabeth
Memphis Tenn.
April 1903

James Mc Cain
W. George Schaefer
Elizabeth
Memphis Tenn.
April 1903

John Mitchell & Son, Inc. 1800 Broadway
New York City
Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05438 CERTIFICATE OF DEATH 05433													
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 37 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore # 24. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1309 Demarcay Way d. STREET ADDRESS 1309 Demarcay Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Walter A. Conrad, Sr.						4. DATE OF DEATH Month May Day 18 Year 19 62							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1896		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster				10b. KIND OF BUSINESS OR INDUSTRY Upholstery Shop				11. BIRTHPLACE (County & State, or foreign country) Carrolltown, Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustine Conrad						14. MOTHER'S MAIDEN NAME Ellen Kaylor							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 162-16-8382		17. INFORMANT Clinical Records, VA Hospital D Fort Howard, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) SQUAMOUS CELL CARCINOMA OF LARYNX DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 11 , 19 62 to May 18 , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 18 , 19 62 , and that death occurred at 2:55 AM from the causes and on the date stated above.													
22a. SIGNATURE Joseph M. Miller M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/18/62					
22c. PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M. D.						22d. ADDRESS VAH, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-62.		23c. NAME OF CEMETERY OR CREMATORY St. Benedict's Cem.				23d. LOCATION (City, town or county) (State) Carrolltown, Pa.					
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler Balto., Md.						25a. REC'D BY REGISTRAR DATE MAY 21 '62		25b. REGISTRAR'S SIGNATURE Wm. S. Thomas					

2.5.15.1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
05439 05434											
1. PLACE OF DEATH e. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS Box 696, Route 2 St. Martin's Lane, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last FREELAND M. COOKE						4. DATE OF DEATH Month Day Year May 3 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 9, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days 02 X 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY Experimental Station				11. BIRTHPLACE (County & State, or foreign country) Chatham County, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cicero Helping Cooke						14. MOTHER'S MAIDEN NAME Margaret Seymour					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 223-16-9745		17. INFORMANT Clinical Records, VA Hospital Fort Howard, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1977 +50X IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH BONE METASTASIS DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (if (this hospital) attended the deceased from March 12 19 62 to May 3 19 62 , that (if) (we) last saw the deceased alive on May 3 19 62 , and that death occurred at 1:20 PM from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5/3/62		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.						22d. ADDRESS VAH, FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 5-7-62		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc. 6009 Harford Rd. 14.						25a. REC'D BY REGISTRAR MAY 7 '62		25b. REGISTRAR'S SIGNATURE Arthur D. Hanes			

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Cook Night Inc. 6005 Bedford St. La.

RECEIVED

[Signature]

U. S. DEPARTMENT OF JUSTICE

Division of Investigation

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05440 CERTIFICATE OF DEATH 05435

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>6yr2m 9dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights, Maryland</u> d. STREET ADDRESS <u>2711 - 79th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gladys</u> First Middle Last 4. DATE OF DEATH <u>May 31</u> 19 <u>62</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/8/1895</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerical worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland Ohio</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Peter Boven</u> 14. MOTHER'S MAIDEN NAME <u>Eva Newton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>276-20-5618</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Coronary sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Diabetes mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>6:15</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Washington</u> (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 22, 1956</u> to <u>May 31, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 31, 1962</u> , and that death occurred at <u>6:15 a.m.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Stella Wachslar</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>5-31-62</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>5/31/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u> 23d. LOCATION (City, town or county) <u>Washington</u> (State) <u>D. C.</u>		25a. REC'D BY REGISTRAR <u>4 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. Washington, D.C.
ADDRESS

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Lee General Home, Washington, D.C.
Division of Social Security
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05441													
05436													
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>200 NEWBURG AVE.</u>						d. STREET ADDRESS <u>1 200 NEWBURG AVE</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA ROBERTA COUNTESS</u>						4. DATE OF DEATH Month Day Year <u>May 2 1962</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 26, 1882</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Charles Lee</u>						14. MOTHER'S MAIDEN NAME <u>Anna Hamilton</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Ruth Murray-200 Newburg Ave.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Disease</u> <u>334X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c) }												INTERVAL BETWEEN ONSET AND DEATH <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3-27-1944</u> to <u>5-2-1962</u> , that (I) (we) last saw the deceased alive on <u>5-2-1962</u> , and that death occurred at <u>A.P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Ken Asleman</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-4-62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Ken Asleman</u>						22d. ADDRESS <u>5907 Hargrave Oak Ave Balt 7, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-7-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie Ind.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Barry Funeral Home-Catonville Ind.</u>						ADDRESS <u>Barry Funeral Home-Catonville Ind.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05442 CERTIFICATE OF DEATH 05437

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 mth 3dys	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 313 E. Cross Street	
3. NAME OF DECEASED (Type or print) Edith B. Cripps		4. DATE OF DEATH May 21, 1962.	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1895
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John F. Doyle		14. MOTHER'S MAIDEN NAME Ida Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary Artry Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Arteriosclerotic Cardio-vascular Dis ease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Decubitus Ulceration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that H (this hospital) attended the deceased from April 18, 1962 to May 21, 1962 that (I) (we) last saw the deceased alive on May 21, 1962 , and that death occurred at 6.45pm from the causes and on the date stated above.			
22a. SIGNATURE H.I. Cholmondeley		22b. DATE SIGNED May 21, 1962	
22c. PHYSICIAN'S NAME (Type) H.I. Cholmondeley		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-1962	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Brooklyn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE S. Howard Strong		25. REC'D BY REGISTRAR DATE MAY 23 '62	
ADDRESS 3207 W. North Ave		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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05443

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>6-BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. LENGTH OF STAY IN lb <u>3-1-62</u> ⁹ <u>WKS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1177 Hall Comre isent-Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest L. Crizer</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>m.</u>		6. COLOR OR RACE <u>wh.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-1877</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD IN BANK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES A. CRIZER</u>		14. MOTHER'S MAIDEN NAME <u>SALLY E. ARMEN TROUT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-40-9414</u>	
17. INFORMANT <u>ELIZ. C. TREXLER</u>		Address <u>8219 PHILA. RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>453.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Gangrene of both feet</u> <u>Buerger's Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on..... <u>5-7-</u>19 <u>62</u> , and that death occurred at..... <u>10 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Dr John Geldrich</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr John GELDRICH</u>		22d. ADDRESS <u>8019 Philad. Rd #6 Balto</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/10/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>		23d. LOCATION (City or town) (County) (State) <u>CLIFTON FORGE, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. W. Hoffmann</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 9 '62</u>	
ADDRESS <u>3218 HUDSON ST.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

VR A15 (4)
1SM 7/61

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05439

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTD.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 34</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BALTIMORE 34</u>		
c. LENGTH OF STAY IN TB <u>12 YRS</u>			d. STREET ADDRESS <u>3026 CALIFORNIA AVE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3026 CALIFORNIA AVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>-</u> Last <u>CRUSSE JR.</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1962</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-20</u>		9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH STEEL</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>LOUIS CRUSSE SR.</u>			14. MOTHER'S MAIDEN NAME <u>HAAAS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>W.W. II</u>			16. SOCIAL SECURITY NO. <u>21376-3699</u>		
17. INFORMANT <u>MRS CRUSSE, 3026 CALIFORNIA AVE.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
2Dc. TIME OF INJURY Hour <u>19</u> e.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William A Pillsbury</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>WILLIAM A PILLSBURY</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>5/31/62</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEMORIAL GARDENS</u>			22d. LOCATION (City, town, or country) (State) <u>BELAIR MD</u>		
23. FUNERAL DIRECTOR <u>C. F. EVANS & SON 8802 HARFORD ROAD</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 1 '62</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

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DATE SIGNED
5-27-62

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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

05445

05440

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catoctinville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>1162 Glendale Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRIETTA</u> Middle <u>E.</u> Last <u>DAILEY</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1962</u>	
S. SEX <u>F</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 26, 1866</u>
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>EDWARD C. EICHELBERGER</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna R. Codwise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Branville B. Dailey</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema - acute</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Generalized arteriosclerotic vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>several wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 3, 1961</u> to <u>date</u> , 19 <u>62</u> , that (II) (we) last saw the deceased alive on <u>May 20, 1962</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John Dr. Gerwig</u> M.D.		22b. DATE SIGNED <u>5-24-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. GERWIG JR.</u>		22d. ADDRESS <u>460 Dralan Rd. Baltors Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>5-28-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		23d. LOCATION (City, town, or county) <u>York, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		25a. REC'D BY REGISTRAR <u>1217 St. Paul St.</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Trane</u>		DATE <u>MAY 28 '62</u>	

Baltimore

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CERTIFICATE OF DEATH

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John ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OVER LEA c. LENGTH OF STAY IN 1b 30 YRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7005 LINDEN AVENUE		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X OVER LEA d. STREET ADDRESS 7005 LINDEN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH A. DANNEMANN		4. DATE OF DEATH Month Day Year MAY 20 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1901 9. AGE (In years last birthday) 61 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECORDER 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE CITY 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME AUGUST DANNEMANN		14. MOTHER'S MAIDEN NAME LENA - MOHL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-6560	
17. INFORMANT MARIE Address Wife - MRS. MARY M. DANNEMANN - 7005 LINDEN AVE.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Cardio-Vascular Hypertensive Disease DUE TO (c) Arteriosclerosis 14 YEARS. 14 YEARS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from March 4, 1948 to MAY 20, 1962 , that (I) (we) last saw the deceased alive on MARCH 30, 1962 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Michael J. Dausch 22c. PHYSICIAN'S NAME (Type) MICHAEL J DAUSCH		22b. DATE SIGNED MAY 20, 1962 22d. ADDRESS 4636 BELAIR ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 23 1962	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM	23d. LOCATION (City, town or county) (State) GERMAN HILL RD MD
24. FUNERAL DIRECTOR'S SIGNATURE Sciffel Bnd ADDRESS 7110 BELAIR RD		25a. REC'D BY REGISTRAR DATE MAY 22 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Walter and the Bear

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 400 ALLEGHENY AVENUE				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 400 ALLEGHENY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LEONORE GRAY DEBAUGH				4. DATE OF DEATH MAY 22, 1962				5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE				8. DATE OF BIRTH NOV. 18, 1868 9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. —				17. INFORMANT FAMILY RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - chronic decompensating 422.1 DUE TO (b) Cerebrocardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 years INTERVAL BETWEEN ONSET AND DEATH years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —			
20f. (City or town) — (County) — (State) —				21. I certify that (I) (this hospital) attended the deceased from 1-1-53 to 5-22-62 , that (I) had last saw the deceased alive on 5-22-62 , and that death occurred 5-22-62 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James G. Saffell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5-23-62			
22c. PHYSICIAN'S NAME (Type) James G. Saffell MD				22d. ADDRESS Peisters town, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF MAY 25, 1962				23c. NAME OF CEMETERY OR CREMATORY STONE CHAPEL CEM.			
23d. LOCATION (City, town or county) PIKESVILLE, MARYLAND				23e. REC'D BY REGISTRAR — 25b. REGISTRAR'S SIGNATURE Arthur L. Hume							
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.				25a. DATE MAY 29 '62							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> g. STREET ADDRESS <u>6726 Collingdale Rd.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Antonio DeGhetto</u> First Middle Last		4. DATE OF DEATH <u>5</u> <u>1</u> <u>1962</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-1877</u> 9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Joseph DeGhetto</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>137107520A</u>	
17. INFORMANT <u>Robert L. DeGhetto</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>General arterio-sclerosis</u> (c) <u>Diabetes + old age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 29, 1962</u> to <u>April 30, 1962</u> ; that (I) <u>(we)</u> last saw the deceased alive on <u>April 30, 1962</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lee K Fargo MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LEE K FARGO MD</u>		22d. ADDRESS <u>8155 Loch Raven Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5-4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Patterson, N.J.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc. 5305 Harford Road</u>		25e. REC'D BY REGISTRAR <u>MAY 4 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)	c. LENGTH OF STAY IN 1b 25 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 256 Riverview Avenue		d. STREET ADDRESS 256 Riverview Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CARLO L. DOLCI		4. DATE OF DEATH Month Day Year May 1st, 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1886
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tin Sorter		10b. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Dolci	
14. MOTHER'S MAIDEN NAME Domenica Rizza		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 213-09-4272		17. INFORMANT Giulia C. Dolci Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days 3-6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 2, 1956 , to May 1, 1962 ; that I last saw the deceased alive on May 1, 1962 , and that death occurred at 9:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Mornington Road DATE SIGNED 5/3/62 ACTUAL SIGNATURE Eugene F. Nevy M.D. Baltimore 22, Maryland PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/4/62	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '62	24b. REGISTRAR'S SIGNATURE Arthur L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05450

05445

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u> c. LENGTH OF STAY IN 1b <u>3 mo. 10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Wilson State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Valley Lee</u> d. STREET ADDRESS <u>Valley Lee</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS WILLIAM DYSON</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8.20.1938</u> 9. AGE (In years last birthday) <u>23</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>5 9 1962</u> Month Day Year 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM DYSON</u> 14. MOTHER'S MAIDEN NAME <u>MARY HEBB</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>220-34-7884</u> 17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lungs</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1.31.1962</u> to <u>5.9.1962</u> that (I) (we) last saw the deceased alive on <u>5.9.1962</u> and that death occurred at <u>5.45</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Newcomer</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u> 22b. DATE SIGNED <u>5.9.1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/12/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. George</u> 23d. LOCATION (City, town or county) (State) <u>Valley Lee Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Fultonardtown Md</u>		25a. REC'D BY REGISTRAR <u>MAY 14 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Funes</u>	

2146 F

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
054451 05446										
CERTIFICATE OF DEATH										
Item 2 Fill in 0313 5/25/62										
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16 S. Prospect Ave. (her home)</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> f. COUNTY <u>BALTIMORE</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u> h. STREET ADDRESS <u>16 S. Prospect Ave</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>T.</u> Last <u>EBERHART</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1962</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 10, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>William F. Schaible</u>					14. MOTHER'S MAIDEN NAME <u>ECKERT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Family</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Occlusion, acute</u> (c) <u>—</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (we) attended the deceased from <u>March</u> 19 <u>59</u> to <u>May 18</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 16</u> 19 <u>62</u> , and that death occurred at <u>8A</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Leo J. Gaver, M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 18, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>					22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 21, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PK. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. MacNabb</u>					ADDRESS <u>301 Frederick Ave #28</u>		25. REC'D BY REGISTRAR <u>MAY 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

(M)

(1)

William F. Schabert
Housewife

✓

F W

Family

Robert

8-2-1932

T. E. Schabert

Caroline

May

19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
05452
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05447

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY NORFOLK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RELAY		c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORFOLK		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RELAY HILL HOSPITAL				d. STREET ADDRESS 6300 RICHMOND PK.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT SKELTON Eggleston				4. DATE OF DEATH Month Day Year MAY 13 19 62			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1882		9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Corporate Officer		10b. KIND OF BUSINESS OR INDUSTRY Auditor		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James A. Eggleston				14. MOTHER'S MAIDEN NAME Nantha Fletcher Shore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 229-10-7806A		17. INFORMANT Mrs. Belia Robertson as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 days Many years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from Sept 6, 1961 to May 13, 1962 and that death occurred on May 13, 1962 at 8:25 M, from the causes and on the date stated above.							
22a. SIGNATURE Lewis P. Gundry				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.				22d. ADDRESS Relay, 27, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/62		23c. NAME OF CEMETERY OR CREMATORY Hollywood		23d. LOCATION (City, town, or county) (State) Richmond, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE William J. Dickner + Sons North + Penna.				ADDRESS		25a. REC'D BY REGISTRAR MAY 14 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Liberty Court Rehabilitation Center						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 11 Overlook Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DOROTHY Middle K Last ESLIN						4. DATE OF DEATH Month May Day 21 Year 1962							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1920		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 13 Days X-2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry C. Kammer						14. MOTHER'S MAIDEN NAME Margaret Walters							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO.						17. INFORMANT James F. Eslin, 11 Overlook Drive, Ellicott City, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinomatosis DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1934 to 5/21 , 19 62 that (I) (we) last saw the deceased alive on 5/21 , 19 62 , and that death occurred at AM , from the causes and on the date stated above.													
22a. SIGNATURE Edward D. Haller M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/21/62				
22c. PHYSICIAN'S NAME (Type) Edward D. Haller						22d. ADDRESS 4300 Libate, Ht 102							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 25, 1962		23c. NAME OF CEMETERY OR CREMATORY Lorraine				23d. LOCATION (City, town or county) (State) Baltimore, Md			
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md						25a. REC'D BY REGISTRAR MAY 24 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes					

00000

00000

Howard

Maryland

Delaware

Illinois City

Philadelphia

11 Overlook Drive

Liberty Court Rehabilitation Center

May 2, 1964

WITH

THOMAS

at

Oct 1, 1960

White

Female

Baltimore, Md

Howe

At Home

Margaret Walters

Henry G. Kanner

James F. Larkin, 11 Overlook Drive, Illinois City, Md

to

Baltimore, Md

Liberty

Prison

F.C. Nigginbohn, Illinois City, Md

TO DEPARTMENT OF HEALTH
FOR STATE HEALTH DEPT.
1
M
X
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03
2
VS. A15ME
5M 7/59

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MAY 14 '62											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05454											
05449											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY IN Bldg. <u>Essex</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Riverside Drive, Balto. 21</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Eastpoint</u> d. STREET ADDRESS <u>404 Woodbine Ave. (24)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JANICE G FAIR</u>						4. DATE OF DEATH <u>MAY 9-62</u> 19 <u>62</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-44</u>		9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolgirl</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver R. Fair</u>						14. MOTHER'S MAIDEN NAME <u>Margaret May Bartholow</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Parents (same as above)</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>891-5</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Overcome by Gas While Parked in Auto</u>							
20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m. 5-9-62</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Public Room</u>		20f. (City or town) <u>Essex-21-Balto Md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>M.B. Davis</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5/10/62</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>5-12-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or country) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR <u>John G. Connelly 418 Eastern Blvd. (21)</u>						24a. REC'D BY REGISTRAR <u>DATE MAY 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

01133

1233



[Faint, mostly illegible handwritten text, possibly a medical or administrative record.]

[Faint, mostly illegible handwritten text, possibly a medical or administrative record.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05455

05450

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY in lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forlygh Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>16</u> d. STREET ADDRESS <u>4133 Norfolk Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Feldman</u> Middle Last 4. DATE OF DEATH <u>May 27</u> 19 <u>62</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>74</u> yrs. last birthday 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Bertha Nathanson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Mr. Melvin Pavsner</u> Address <u>5537 Lynview Avenue</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>stasis ulcers of legs</u> (c) <u>stasis ulcers of legs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>stasis ulcers of legs</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1403 Foley Lr. Pikesville Md.</u> 20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>23 May 1962</u> to <u>27 May 1962</u> that (I) <u>last</u> saw the deceased alive on <u>26 May 1962</u> and that death occurred <u>11:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul H Royse</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE</u>		22b. DATE SIGNED <u>May 27, 1962</u> 22d. ADDRESS <u>1403 Foley Lr. Pikesville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/28/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Mens</u> 23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson & Bros. Inc. 6010 Reisterstown Rd.</u> 25a. REC'D BY REGISTRAR <u>MAY 29 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

5232

5232

1914

May 10

1915

May 10

1916

May 10

1917

May 10

1918

May 10

1919

May 10

1920

May 10

1921

May 10

1922

May 10

1923

May 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05456

CERTIFICATE OF DEATH

05451

Item 8 Film G312 5/15/62 jvk

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY in 1b Life		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 735 Anneslie Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche P. Fisher		First		Middle		Last		4. DATE OF DEATH May 9 1962		Day		Month		Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 1896 10-17-1896		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Newport News, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Henry A. Pollock		14. MOTHER'S MAIDEN NAME Laura V. McNamee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-9152		17. INFORMANT Mr. Jas. T. Fisher		Address 1764 Joan Ave. Towson 4 Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 157x Carcinoma of the pancreas DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 1-2 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Towson		(County) Balt.		(State) Md.					
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19....., to 5/9/62 , 19....., that (I) (we) last saw the deceased alive on 5/9/62 , 19....., and that death occurred at 5:47 AM , from the causes and on the date stated above.															
22a. SIGNATURE Ernest C. Brown Jr.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Ernest C. Brown Jr.				22d. ADDRESS 550 N. Broadway-5											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-62		23c. NAME OF CEMETERY OR CREMATORY Monte Marie Cem.		23d. LOCATION (City, town or county) Towson, Balt. Co. Md.		(State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balt. 12, Md.		25a. REC'D BY REGISTRAR MAY 10 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House									

1250

8151

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05452

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4505 Wilkins Ave		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4505 Wilkins Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edmund M. Middle Fisher Last 4. DATE OF DEATH Month May Day 3 Year 1962		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 19, 1899 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY self 11. BIRTHPLACE (State or foreign country) Connecticut 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilford Fisher 14. MOTHER'S MAIDEN NAME Almina LePine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Address Irene M. Watkinson, 175 Poplar St. Bridgeport Conn.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 42011 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Geo. S. M. Kieffer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D. DATE SIGNED May 3, 1962 Address (Street, city, town, or county) 1010 Leeds Ave 29			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/7/62 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue #29 24e. REC'D BY REGISTRAR MAY 7 '62 24f. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DISCUSS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/62

(M)

Baltimore

Address

4205 Wilkins Ave

Edward M. Fisher

Self White

Carpenter

Wilford Fisher

James

Age

Coroner v. Thompson

Mr.

Address

4205 Wilkins Ave

May 2, 1902

May 12, 1902

Connecticut

Alma Fisher

James M. Thompson, 175 Polk St. Baltimore

Conn.

May 2, 1902

4205 Wilkins Ave

Geo. S. K. Fisher

Age

James M. Thompson

James M. Thompson, 175 Polk St. Baltimore

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05458											
Reg. Dist. No. 05453											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u> Conn.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks, Md.</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Quaker Bottom Rd.</u>					d. STREET ADDRESS <u>Quaker Bottom Rd.</u>						
3. NAME OF DECEASED (Type or print) <u>Gladys Ardella Fisher</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1962</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-1907</u> 54 yrs.		9. AGE (In years last birthday)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pinney Grove, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>		
13. FATHER'S NAME <u>Samuel Larkins</u>					14. MOTHER'S MAIDEN NAME <u>Mary Figgett</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Moses Fisher Quaker Bottom Rd.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>A. M. France</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>5/13/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevenson AME Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morton + Dye & Fun. Home</u>						ADDRESS <u>BALTO., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 16 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

(M)

X

(I)

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2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1912

NAME OF DECEASED
RESIDENCE
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

DATE OF EXAMINATION
PLACE OF EXAMINATION
NAME OF EXAMINER
SIGNATURE OF EXAMINER

STATE OF MASSACHUSETTS
COUNTY OF
CITY OF
TOWN OF
DECEASED
RESIDENCE
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
DATE OF EXAMINATION
PLACE OF EXAMINATION
NAME OF EXAMINER
SIGNATURE OF EXAMINER

CERTIFICATE OF DEATH

Reg. Dist. No.

05459

05454

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (19)		c. LENGTH OF STAY IN 1b 26 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (19)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7340 Waldman Avenue				d. STREET ADDRESS 7340 Waldman Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER RAYMOND FORNWALT				4. DATE OF DEATH Month May Day 19th Year 19 62			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1897	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Fornwalt				14. MOTHER'S MAIDEN NAME Fannie (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-4382		17. INFORMANT Ella Z. Fornwalt		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma lung 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH July 1958	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3rd., 1951 , to May 19., 1962 , that I last saw the deceased alive on April 25th., 1962 , and that death occurred at 6:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6908 North Point Road DATE SIGNED 5/19/62							
ACTUAL SIGNATURE Louis N. Tollin		M.D. 6908 North Point Road 5/19/62					
PHYSICIAN'S NAME (Type) Louis N. Tollin, M.D.		Baltimore 19, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE MAY 23 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

PLACE OF BIRTH _____		PLACE OF DEATH _____	
DATE OF BIRTH _____		DATE OF DEATH _____	
SEX _____		RACE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
NAME OF DECEASED _____		NAME OF ATTENDING PHYSICIAN _____	
ADDRESS OF DECEASED _____		ADDRESS OF PHYSICIAN _____	
CITY AND COUNTY _____		STATE _____	
COUNTY _____		DISTRICT _____	
WARD _____		BLOCK _____	
HOUSE NO. _____		STREET _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF PHYSICIAN _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	
NAME OF REGISTRAR _____		NAME OF CLERK _____	
ADDRESS OF REGISTRAR _____		ADDRESS OF CLERK _____	
CITY AND COUNTY _____		STATE _____	
COUNTY _____		DISTRICT _____	
WARD _____		BLOCK _____	
HOUSE NO. _____		STREET _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	

100-100000

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND IN THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05460 CERTIFICATE OF DEATH 05455

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>5800 Harford Rd</u>			
c. LENGTH OF STAY IN 1b <u>1 yr - 1 mo</u>				d. STREET ADDRESS <u>3401-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Aged Women + Aged Men's Homes</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Peter Forthuber</u>				4. DATE OF DEATH Month Day Year <u>May 22 1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-13-1891</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Retail Florist</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Emil G. Forthuber, Sr</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Hawer Haur</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>220-01-5667</u>			
17. INFORMANT <u>Gloria Sherman</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1962</u> to <u>May 22, 1962</u> that (I) (we) last saw the deceased alive on <u>May 21, 1962</u> , and that death occurred <u>3:55</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>William E. Day</u>				22b. DATE SIGNED <u>May 24, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>M.D.</u>	
22d. ADDRESS <u>H-E-33rd Balto 18</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 25-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Gork-Towson</u>				ADDRESS <u>1050 York Rd. Towson, Md</u>		25a. REC'D BY REGISTRAR <u>May 28 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05461

05456

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) STEMMERS RUN. c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1003 RACE ROAD #21 MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) STEMMERS RUN. d. STREET ADDRESS 1003 RACE ROAD #21 MD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Grover First C Middle FRANK Last		4. DATE OF DEATH 5 Month 2 Day 1962 Year		5. SEX Male		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 2, 1885		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY FIREMAN				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME JOSEPH FRANK				14. MOTHER'S MAIDEN NAME MARY UNKNOWN													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 218-18-3448				17. INFORMANT JOSEPH FRANK 1003 RACE ROAD #21, MD Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cocaine Conditions, if any, which gave rise to immediate cause (b) 420.1 (a), stating the underlying cause last. DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1												INTERVAL BETWEEN ONSET AND DEATH 10 min					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour e.m. p.m. 19		Month, Day, Year 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTO CO. (County) MARYLAND (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JACK C COLLINS				Address (Street, city, town, or county)				DATE MAY 4 '62				24b. REGISTRAR'S SIGNATURE Arthur L. Hume					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF MAY 5, 1962		22c. NAME OF CEMETERY OR CREMATORY 2100 LUTHERAN				22d. LOCATION (City, town, or country) BALTO CO. MARYLAND (State)							
23. FUNERAL DIRECTOR Nassahn Funeral Home 7401 Belair Rd. #36.				ADDRESS				24a. REC'D BY REGISTRAR MAY 4 '62				24b. REGISTRAR'S SIGNATURE					

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSMC
SM 9/60

<div> <div>Item 10 Form 513 5-10</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>05462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05457</div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thornleigh				c. LENGTH OF STAY IN 1b X Thornleigh				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1623 Alston Road						d. STREET ADDRESS 1623 Alston Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anne Marie Friedel						4. DATE OF DEATH Month Day Year 5/10/62					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 14, 1960		9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George A. Friedel, Jr.						14. MOTHER'S MAIDEN NAME Doris Marie Reuter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. George A. Friedel, Jr. - 1623 Alston Road					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tracheobronchitis & interstitial 500 X pneumonitis, marked Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE R. Breiteneker M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) May 11, 1962											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-62		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or country) (State) Pikesville, Maryland					
23. FUNERAL DIRECTOR ADDRESS Wm J. Suckewer & Sons Baltimore 17 Md.						24a. REC'D BY REGISTRAR DATE MAY 14 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05463 CERTIFICATE OF DEATH 05458

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 2yr 27days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2011 West Pratt Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		4. DATE OF DEATH May 8 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> separated	8. DATE OF BIRTH Nov. 9, 1893
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator	11. BIRTHPLACE (County & State, or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown	
16. SOCIAL SECURITY NO. 219-12-6392		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 10 1960 to May 8 1962 , that (I) (300) last saw the deceased alive on May 8 1962 , and that death occurred at 9:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 5-8-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10 1962	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Old Frederick Road Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Kraus Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 5yr10mth21dys		d. STREET ADDRESS 300 N. Hilton St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle A. Last German		4. DATE OF DEATH Month May Day 23 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1896
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harry Dunphy		14. MOTHER'S MAIDEN NAME Annie Alter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 410 X DUE TO Cardiac hypertrophy due to dilatation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Chronic mitral endocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -			
INTERVAL BETWEEN ONSET AND DEATH -			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 10 (this hospital) attended the deceased from July 29, 1966 , to May 23, 1962 , that (X) (we) last saw the deceased alive on May 23, 1962 , and that death occurred at a.m. , from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D.		22b. DATE SIGNED 5-23-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-28-62	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2		25a. REC'D BY REGISTRAR MAY 28 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank		25c. DATE MAY 28 '62	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1201 Boyce Ave.				d. STREET ADDRESS 1201 Boyce Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK JOHN GOEBEL		First Middle Last		4. DATE OF DEATH May 12, 1962		Month Day Year 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1893	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Vice Pres		11. BIRTHPLACE (County & State, or foreign country) Indianna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Goebel				14. MOTHER'S MAIDEN NAME Cora Small			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 705-12-1537		17. INFORMANT Mrs Fred H. Robb, Rfd 1 McKee Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) & Generalized Metastasis (c) Carcinoma of Prostate				INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1950 to May 12, 1962 that (I) (we) last saw the deceased alive on May 11, 1962 and that death occurred at 3A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 2501 York Rd #4 Md 11/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/62		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION (City, town or county) (State) Baltimore County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. - Cook Towson Inc				25a. REC'D BY REGISTRAR 1050 York Rd., Towson 4, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



Attorneys

Townson

1201 Boyce Ave.

RAHAK

White

Retired Vice Pres

John Gooden

No

Maryland

Townson

1201 Boyce Ave.

JOHN

apt. 26, 1893

8 & 9 Railroad Indiana

John Small

Attorneys

May 12, 1965

88

USA

705-12-1537 was Fred H. Good, and I agree to

Handwritten notes:
What is the name of the
company that is
the owner of the
property?

Serial

Mr. - Cook Townson Inc

Pinney Valley Cem.

1070 York Rd.
Townson, Md.

Attorneys Council, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05466
05461

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 51 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON d. STREET ADDRESS 2029-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES E. GOLT		4. DATE OF DEATH Month May Day 5 Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1889
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months 5 Days 19	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roland A. Golt		14. MOTHER'S MAIDEN NAME Henrietta Messick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-01-8273	
17. INFORMANT Clinical Records VAH, Fort Howard, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA, CHRONIC LYMPHATIC 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 15 Mar 1962 to 5 May 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5 May 1962 , and that death occurred at 8:05 AM , from the causes and on the date stated above.		22a. SIGNATURE Donald W. Stewart M.D. 22b. DATE SIGNED 5/5/62	
22c. PHYSICIAN'S NAME (Type) DONALD W. STEWART, M.D.		22d. ADDRESS VAH, Fort Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/8/62	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	23d. LOCATION (City, town or county) Easton, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Carroll W. Hampton Carroll		25a. REC'D BY REGISTRAR MAY 8 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

10400

MASSACHUSETTS

WESTON

PORT HANCOCK

VA. HANCOCK INVESTIGATION HOSPITAL

02

MAY

COURT

CHURCHES

13

MAY 2, 1889

WHITE

WILL

U.S.A.

STATE HOUSE, WESTON, MASSACHUSETTS

NO. 102

Honorable Member

Honorable

Official Records
V.A., Port Hancock, Maryland

SEP-01-89

WM I

Yes

3 yrs.

LEUKAEMIA, CHRONIC LYMPHATIC

02

02

MAY

SEP

12 MAY

02

MAY

2

1889

Official Records, V.A., Port Hancock, Maryland

Official Records, V.A., Port Hancock, Maryland

Official Records, V.A., Port Hancock, Maryland

Official Records, V.A., Port Hancock, Maryland

Official Records, V.A., Port Hancock, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND - STATE DEPARTMENT OF HEALTH -

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05467

05462

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN TB 37 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3212 Avon Avenue d. STREET ADDRESS 3212 Avon Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James C. Gowland		4. DATE OF DEATH Month May Day 7 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1925
9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman	11. BIRTHPLACE (County & State, or foreign country) York, England
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Gowland	
14. MOTHER'S MAIDEN NAME Margaret Boynton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 218-18-1685		17. INFORMANT Clinical Records Folder, V.A. Hospital Fort Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X XXXX Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. RIGHT LOBAR PNEUMONIA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 3 DAYS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) March 31, 1962, to May 7, 1962		(County) Baltimore	
(State) Md		21. I certify that (H) (this hospital) attended the deceased from March 31, 1962 , to May 7, 1962 , that (H) (we) last saw the deceased alive on May 7, 1962 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.	
22a. SIGNATURE S. Russo		22b. DATE SIGNED 5/7/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/10/62	
23c. NAME OF CEMETERY OR CREMATORY LOYDON PARK		23d. LOCATION (City, town or county) BALTIMORE	
(State) Md		24. FUNERAL DIRECTOR'S SIGNATURE LJ Ruck Inc 5305 HARFORD RD.	
25a. REC'D BY REGISTRAR MAY 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00-85

00-85



Handwritten notes and stamps, including "FEDERAL BUREAU OF INVESTIGATION" and "U.S. DEPARTMENT OF JUSTICE".

Handwritten notes and stamps, including "FEDERAL BUREAU OF INVESTIGATION" and "U.S. DEPARTMENT OF JUSTICE".

CERTIFICATE OF DEATH

05468

05463

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie			
c. LENGTH OF STAY IN 1b 46 Days				d. STREET ADDRESS 105 Central Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Served as: Horace W. Gregoire				4. DATE OF DEATH Month May Day 11 , Year 19 62			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH April 3, 1898			
9. AGE (In years last birthday) 64 yrs.				IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer				10b. KIND OF BUSINESS OR INDUSTRY Carton Company		11. BIRTHPLACE (County & State, or foreign country) Hillsboro County N. H.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Gregory				14. MOTHER'S MAIDEN NAME Odellie Dupree			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-1 024-09-3354			
17. INFORMANT Clinical Records, VAH, Fort Howard, Maryland				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT LOBAR PNEUMONIA							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CIRRHOSIS OF LIVER							
(c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26 19 62 to May 11 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 11 19 62 , and that death occurred at 2 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Sebastian Russo				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-11-62	
22c. PHYSICIAN'S NAME (Type) Sebastian Russo				22d. ADDRESS M.D. VAH, Fort Howard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-14-62		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. 14.				25a. REC'D BY REGISTRAR MAY 16 62		25b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

12345

Belmont

Post Office

Served as: Horse

XX

White

Mechanical Engineer

George Gregory

Yes

XXXX

CHIEFS OF LIVES

LETTER FROM

021-02-1351

Oblique Engineer

Carson Company Hillboro County N. H.

U.S.A.

April 2, 1898

Yes

negotiate

102 Central Avenue

John Smith

England

11-02

Serial

2-11

United States

Missville

Missville

Black Mountain and 5000

Sebastian Russo N.D. VAN, Fort Howard, Maryland

X

2-11-02

11-02

March 20, 02

X

X

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05469

05464

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Fort Howard		c. LENGTH OF STAY IN b	
		3 Days		X Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Veterans Administration Hospital		3337 Woodside Avenue	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH	
DONALD W. GRITZ				May 12 19 62	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Male		White		8. DATE OF BIRTH	
				April 27, 1931	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Bartender		Tavern		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John R. Gritz		Margaret M. Arnal		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes Korean Conflict		213-28-2212		Clinical Records Vet. Adm. Hosp., Ft Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
201X		HODGKINS DISEASE		UNKNOWN	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) DUE TO			
		(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
May 12 1962				20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 9 1962 to May 12 1962, that (X) (we) last saw the deceased alive on May 12 1962, and that death occurred at p.m., from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED	
John D. Talbert		M.D.		5-13-62	
22c. PHYSICIAN'S NAME (Type)		John D. Talbert, M.D.		22d. ADDRESS	
				Vet. Adm. Hosp., Fort Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/16/62		Parkwood Cemetery	
				Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
Lemard J. Ruok Inc		5305 Hanford Rd		DATE MAY 15 '62	
				25b. REGISTRAR'S SIGNATURE	
				Arthur S. Kraus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

(M)

Baltimore

Baltimore

Fort Howard

3 days

Baltimore

Veterans Administration Hospital

3337 Woodside Avenue

DOWNED

W.

ORITZ

Key

62

X

April 27, 1931

White

Harbor

Tavern

Baltimore, Maryland

U.S.A.

John E. Oritz

Margaret H. Oritz

See Korean Conflict 213-28-2212 Clinical Records Vet. Adv. Hosp., Ft. Howard, Md.

WEDDING DISEASE

UNKNOWN

X

May 12

May 9 10:40 p.

May 12

May 12

John D. Talbert, M.D., Vet. Adv. Hosp., Fort Howard, Maryland

Larson's Laboratory

Baltimore

air land

2-13-62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05470

05465

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winters Lane Extended		d. STREET ADDRESS Winters Lane Extended	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Louise Last Gross		4. DATE OF DEATH Month May Day 11 , Year 1962	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1884
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cornelius Gross		14. MOTHER'S MAIDEN NAME Annie Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rachel A. Gross		Address Winters Lane Extended	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arterio-sclerosis 11 yrs. 4 mo. 5 Days DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 6th 1961 to May 11th 1962, that (I) (we) last saw the deceased alive on May 11th 1962, and that death occurred at 10 M, from the causes and on the date stated above.			
22a. SIGNATURE C.F. Maloney		22b. DATE SIGNED May 11-1962	
22c. PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.		22d. ADDRESS 57 Winters Lane, Catonsville-28. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/62	
23c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery		23d. LOCATION (City, town, or county) (State) Catonsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE A. Halstead		25a. REC'D BY REGISTRAR May 14 '62	
25b. REGISTRAR'S SIGNATURE Charles L. Thomas			

Balto. 1, Md.

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CERTIFICATE OF DEATH

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Name of deceased		Date of death	
Place of death		Cause of death	
Age at death		Sex	
Marital status		Occupation	
Signature of physician		Signature of registrar	
Date of registration		Place of registration	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05471

05466

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>Offutt Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Groves</u> Last <u>Groves</u>				4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891 - Aug. 5</u>		9. AGE (In years lost birthday) yrs. <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer throughout life</u>		11. BIRTHPLACE (State or foreign country) <u>unknown Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown Auburn Groves</u>				14. MOTHER'S MAIDEN NAME <u>unknown Elizabeth Shippe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Hypertensive arteriosclerotic Heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia due to 3 cerebrovascular accidents since 1958</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 29, 1962</u> to <u>May 8, 1962</u> , that (2) (we) last saw the deceased alive on <u>May 8 19 62</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachsler</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>5-8-62</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-11-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woods Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Adelby Rd. Balt Co, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther Haight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 14 '62</u>	
						25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
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05467																	
Item 1c Film G313 6/21/62 iwk																	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN (b) Unknown d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital Catonsville, Maryland						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 254 S. Monastery Ave. Balto. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Peter Frank GUBERNATIS						4. DATE OF DEATH Month 5 Day 13 Year 1962											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-20-77		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Gubernatis						14. MOTHER'S MAIDEN NAME Anna UNKNOWN											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown				16. SOCIAL SECURITY NO. 212-14-2728				17. INFORMANT Address Hospital Record									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 443X DUE TO Generalized Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) Undetermined (a), stating the underlying cause last. DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from April 12, 1962 , to May 13, 1962 , that (I) (we) last saw the deceased alive on May 13, 1962 , and that death occurred at 1 P.M. from the causes and on the date stated above. 22a. SIGNATURE Gertrude J. Fleischman M.D. 22b. DATE SIGNED 5.13.1962 22c. PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMAN 22d. ADDRESS Spring Grove ST. H. Catonsville																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF May 16, 1962				23c. NAME OF CEMETERY OR CREMATORY New Cathedral CEM. Balto. Md.				23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE G. TRUMAN Schaub 3512 Fred. Ave. (29)						25a. REC'D BY REGISTRAR MAY 15 '62						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

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G. Truman School
219 Ford Ave. (22)
Burling Mariposa New Cathedral Cn Bldg 1/4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore Co.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b app 17 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 402 Meadow Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 402 Meadow Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EMMALENE NANCY HAHN					4. DATE OF DEATH May 28, 1962						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 10, 1920		9. AGE (In years last birthday) 41 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bendix Corp.			10b. KIND OF BUSINESS OR INDUSTRY Oklahoma			11. BIRTHPLACE (State or foreign country) USA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Seago					14. MOTHER'S MAIDEN NAME Addie ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) none					16. SOCIAL SECURITY NO. yes					17. INFORMANT Russell E. Hahn Address 402 Meadow Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal infarction 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Thrombotic occlusion of abdominal aorta DUE TO (c) Arteriosclerotic cardiovascular disease										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)			(County)			(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Howard G. Shaub					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 29, 1962				
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.					Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF May 31, 1962			22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			22d. LOCATION (City, town, or country) Baltimore, Maryland		
23. FUNERAL DIRECTOR John A. Moran ADDRESS 3000 E. Baltimore St.					24a. REC'D BY REGISTRAR JUN 1 '62			24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

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Handwritten signature

IN THE COURT OF THE UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY in b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 50 WINTERS LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH J. HALL		4. DATE OF DEATH Month Day Year MAY 20 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Handyman		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Hall		14. MOTHER'S MAIDEN NAME Susan Nugent	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-14-0427	
17. INFORMANT Clinical Records, VA Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) MASSIVE HEMORRHAGE FROM ESOPHAGEAL VARICES (c) CIRRHOSIS OF LIVER	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 5 DAYS 6 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While Not While of work of work <input type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from May 18 1962 , to May 20 1962 , that (I) (we) last saw the deceased alive on May 20 1962 , and that death occurred at 8:20PM from the causes and on the date stated above.			
22a. SIGNATURE Joseph M. Miller M.D.		22b. DATE SIGNED 5/20/62	
22c. PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M. D.		22d. ADDRESS VAH FORT HOWARD MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR MAY 24 '62	
ADDRESS 1808 N. MONROE ST.		25b. REGISTRAR'S SIGNATURE Wm. S. Thomas	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05475											
05470											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY in 1b <u>125 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1202 W. 40th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>BRADLEY</u> Middle <u>D.</u> Last <u>HALLEY</u>						4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 5, 1895</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles F. Halley</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Brown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Clinical Records, VA Hospital, Fort Howard, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>490X</u> IMMEDIATE CAUSE (a) <u>BILATERAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BENIGN PROSTATIC HYPERTROPHY. RIGHT PYELONEPHRITIS</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. TIME OF INJURY Hour <u>-</u> e.m. <u>-</u> p.m. <u>19</u>		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town)		20e. (County)		20f. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 20, 1962</u> to <u>May 25, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 25, 1962</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Sebastian Russo</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5/25/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M. D.</u>						22d. ADDRESS <u>VAH FORT HOWARD, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-28-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l.</u>		23d. LOCATION (City, town or county) <u>Balto.</u>		23e. (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>						ADDRESS <u>4905 York Rd. Balto.</u>		25a. REC'D BY REGISTRAR <u>MAY 28 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05476
05471
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 5yr8mthldy			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 4720 Wheeler Road			
3. NAME OF DECEASED (Type or print) Catherine Harleston				4. DATE OF DEATH May 23 19 62			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1887	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Charles Harleston				14. MOTHER'S MAIDEN NAME Ellen Keyes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (This hospital) attended the deceased from Sept. 20, 1956 to May 23, 1962, that (we) last saw the deceased alive on May 23, 1962, and that death occurred at 8:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar M.D. 22b. DATE SIGNED 5-23-62 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/25/62 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet 23d. LOCATION (City, town or county) (State) Washington, D.C.							
24. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, Inc. 307 PA. AVE., S.E. WASH. D.C. 25a. REC'D BY REGISTRAR DATE MAY 28 '62 25b. REGISTRAR'S SIGNATURE							

11360

11360

(M)

Washington, D.C.

Mr. Oliver

2/25/62

Bureau

215 West 11th St.
New York, N.Y.

James T. [unclear]
[unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05477

CERTIFICATE OF DEATH

05472

Item 2 Film 0313 5/28/62 mh

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>444THAVENUE Baltimore 18</u>	
c. LENGTH OF STAY IN 1b <u>10 mos.</u>		d. STREET ADDRESS <u>1309 Windemere Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Maryland Masonic Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Alberta</u> Last <u>Harrison</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1898</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Balto City, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Albert W Harrison</u>	
14. MOTHER'S MAIDEN NAME <u>Mary McNeir</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Masonic Home Records - Cockeysville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchopneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>May 20</u> to <u>May 21</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 20</u> , 19 <u>62</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth R. Shearill</u> M.D.		22b. DATE SIGNED <u>5/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth R. Shearill MD</u>		22d. ADDRESS <u>Cockeysville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-24-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>		25a. REC'D BY REGISTRAR <u>MAY 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>		25c. DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05478 CERTIFICATE OF DEATH 05473

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrison, Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrison, Maryland d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Virginia Elizabeth Harrison First Middle Last			4. DATE OF DEATH May 26, 1962 Month Day Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1885	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Horace W. White					
14. MOTHER'S MAIDEN NAME Jane Mary Ward		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					
16. SOCIAL SECURITY NO. 220-30-4966		17. INFORMANT Mr. David R.W. Harrison, Garrison, Maryland Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 1 1/2 year							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1949 to May 26 1962 , that (I) was last saw the deceased alive on 25 May 1962 , and that death occurred at 1230 AM , from the causes and on the date stated above.							
22a. SIGNATURE Paul H Royse 22c. PHYSICIAN'S NAME (Type) PAUL H ROYSE			22b. DATE SIGNED 26 May 62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1403 Foley Ct Pikesville Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 28, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery			
23d. LOCATION (City, town or county) Garrison Forrest, Md.		23e. REC'D BY REGISTRAR 5 '62					
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell Pikesville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 23b, Film G323 10/2/62											
06718											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY in 1b 5 1/2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 522 West Langvale St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Allen HAYNIE						4. DATE OF DEATH Month Day Year 5 31 19 62					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/44		9. AGE (In years last birthday) 17 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Haynie						14. MOTHER'S MAIDEN NAME Ellen Day					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. ---		17. INFORMANT Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to aspiration of stomach contents 351X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Epilepsy (c) Quadruplegia with symptomatic epilepsy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Quadruplegia with symptomatic epilepsy INTERVAL BETWEEN ONSET AND DEATH 4 days											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (H) (this hospital) attended the deceased from 10/1 , 19 56 , to 5/31 , 19 62 , that (W) (we) last saw the deceased alive on 5/31 , 19 62 , and that death occurred at 4:15 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Larry B. Butler M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 June '62			
22c. PHYSICIAN'S NAME (Type) Owings Mills, Md.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 5, 1962 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery, Baltimore, Md. 23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home ADDRESS 1631 Druid Hill Ave.						25a. REC'D BY REGISTRAR JUN 7 '62 DATE		25b. REGISTRAR'S SIGNATURE Charles S. Hume			

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Salisbury

Orange Hills

St. Paul

Rosewood State Training School

322 West Longview St.

Joseph

HARVEY

Allen

Henry

1914

none

Salisbury City, MA.

Ellen Day

William Henry

Board of Trustees, Orange Hills

Brotherhood of the Holy Spirit

Salisbury, MA.

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CERTIFICATE OF DEATH

05480

05474

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1804 E. Pratt St. 3520 Hilton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorraine Middle Henroid Last May		4. DATE OF DEATH Month May Day 21 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65	11. IF UNDER 24 HRS. Hours 65 Min. 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME (Retired)	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. 214-22-1613	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that it (this hospital) attended the deceased from April 24 9:45 to May 21 1962 , that we (we) last saw the deceased alive on May 21 1962 , and that death occurred at 6 P. , from the causes and on the date stated above.	
22a. SIGNATURE Stella Wachsler M.D.		22b. DATE SIGNED 5-22-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY-24-1962	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cem	23d. LOCATION (City, town or county) (State) BALTO, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Gannino ADDRESS 2635 Conkling St.		25a. REC'D BY REGISTRAR MAY 29 1962 25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

05481

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05475

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in lb <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		301-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Nursing Home</u> <u>Paradise and Altamont Avenues</u>				d. STREET ADDRESS <u>3334 Keswick Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Belle</u> Middle <u>J.</u> Last <u>Hermes</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> N. ER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1872</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Richard Jones</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William H. Surratt</u> Address <u>3334 Keswick Road Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arthritis, Rheumatoid, severe- Decubitus Ulcers- Buttocks & Sacrum</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> e.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>58</u> (County) <u>5/20/62</u> (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/19/62</u> to <u>5/21/62</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>5/19/62</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. E. McGrath, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. McGrath, M.D.</u>				22d. ADDRESS <u>1303 Frederick Rd., Catonsville 28</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 22, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> <u>Horace T. Burgee</u>				ADDRESS <u>3631 Falls Road</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 22 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

05250

131

(M)

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO: SAC, HONOLULU
FROM: SAC, SAN FRANCISCO
SUBJECT: [illegible]

RE: [illegible]
[illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]

6. [illegible]
7. [illegible]

8. [illegible]
9. [illegible]

10. [illegible]
11. [illegible]

12. [illegible]
13. [illegible]

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>05482</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>05476</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS	
					X			1 1813 Hanford Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Residence									
3. NAME OF DECEASED (Type or print) <u>HERMAN LEROY HESS</u>					4. DATE OF DEATH Last <u>May</u> 8 19 <u>62</u>				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-27-1908		53 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Elec. Estimator					Maryland		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
Frank Hess			Lillian Lemcke						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			216108935		Bernice R. Hess		same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arteriosclerotic heart disease with</u> <u>420.1</u> DUE TO <u>marked pulmonary and visceral congestion and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary edema</u> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		Partial				(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>R. Breiteneker</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Rudiger Breiteneker, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 8, 1962</u>				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)	
burial		5-11-62		Trinity Ev. Lutheran		Baltimore County		Md.	
23. FUNERAL DIRECTOR					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
L. J. Ruck Inc. 5305 Harford Road					MAY 10 '62		Arthur L. Hanna		

00111

001

11-1-10

101-101

11-10

11-10-10

CERTIFICATE OF DEATH

05477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (24)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (24)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 South 49th Street		d. STREET ADDRESS 708 South 49th Street	
3. NAME OF DECEASED (Type or print) WALTER PARCELS HESS		4. DATE OF DEATH Month May Day 21st Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Core Maker		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel D. Hess		14. MOTHER'S MAIDEN NAME Laura M. Lessick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-01-6385	
17. INFORMANT Walter E. Hess, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS-C-V-R-DISEASE 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 14, 1961 to May 21, 1962 , that I last saw the deceased alive on May 21, 1962 , and that death occurred at 6800 Morningside Road , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M. B. Davis M.D. 6800 Morningside Road 5/22/62 PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D. Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/62	22c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery	22d. LOCATION (City, town, or county) (State) Lewistown, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE MAY 24 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. DIST. NO.

FILE NO.

PLACE OF DEATH _____		COUNTY _____	
CITY OR TOWNSHIP _____		STATE _____	
DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		COUNTY OF BIRTH _____	
OCCUPATION _____		MARITAL STATUS _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
MEDICAL HISTORY _____		SOCIAL HISTORY _____	
PHYSICIAN'S SIGNATURE _____		DEATH CERTIFICATE NO. _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF INTERMENT _____		NAME OF INTERMENT SOCIETY _____	
NAME OF FUNERAL HOME _____		ADDRESS OF FUNERAL HOME _____	
NAME OF NEXT OF KIN _____		ADDRESS OF NEXT OF KIN _____	
NAME OF CORONER _____		ADDRESS OF CORONER _____	
NAME OF REGISTRAR _____		ADDRESS OF REGISTRAR _____	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05484

05478

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bent's Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>12020 Ruston Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Will</u> Last <u></u>		4. DATE OF DEATH Month <u>5</u> - Day <u>25</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In General</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Bent</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u></u> p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 27</u> 19 <u>62</u> to <u>May 25</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>May 25</u> 19 <u>62</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Clarence E. McWilliams</u> M.D.		22b. DATE SIGNED <u>May 25, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Keisterstown Maryland</u>		22d. ADDRESS <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/64</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Albans</u>		23d. LOCATION (City, town, or county) (State) <u>Brooklyn Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. O. Wilson</u> ADDRESS <u>1000 North St</u>		25a. REC'D BY REGISTRAR <u></u> DATE <u>1 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thane</u>			

2830

920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05485

CERTIFICATE OF DEATH

05479

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>4 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7624 Old Battle Grove Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 24 3rd 1st 4</u> d. STREET ADDRESS <u>6706 German Hill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel D. Hollingshead</u> First Middle Last 4. DATE OF DEATH <u>May 30, 1962</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 10, 1884</u> Last First Middle 9. AGE (In years last birthday) <u>77</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Freeland, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Daniel F. Wilhelm</u> 14. MOTHER'S MAIDEN NAME <u>Eliza Kirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>7624 Old Battle Grove Rd. Dundalk 22, Md.</u> 17. INFORMANT <u>Nary Hollingshead</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> DUE TO (b) <u>Arterio-sclerotic Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>20 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 wks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>30 April 62</u> to <u>30 May 62</u> that (I) (we) last saw the deceased alive on <u>28 May 1962</u> and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>W. H. Morrison</u> M.D. 22b. DATE SIGNED <u>30 May 62</u> 22c. PHYSICIAN'S NAME (Type) <u>W. H. Morrison</u> 22d. ADDRESS <u>3 Kinship Rd, Dundalk, 22 Md.</u> 22e. REC'D BY REGISTRAR <u>JUN 4 62</u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF <u>Burial June 3, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Freeland, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Portenstein, New-Freedom, Pa.</u> ADDRESS <u>New-Freedom, Pa.</u> 25a. REC'D BY REGISTRAR <u>JUN 4 62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

(M)

British James P. McLean Cemetery, Fredericton, New Brunswick, Canada

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>301-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines- 16 Fusting Ave.</u>				d. STREET ADDRESS <u>910 Walnut Avenue #29</u>			
3. NAME OF DECEASED (Type or print) First <u>Garfield</u> Middle <u>F.</u> Last <u>Horsmon</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mc Lellan Horsmon</u>				14. MOTHER'S MAIDEN NAME <u>Ann Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>218-28-1814</u>		INFORMANT Address <u>Mrs. Helen E. Horsmon-910 Walnut Avenue #29</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1-2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>62</u> to <u>May 20</u> , 19 <u>62</u> that I last saw the deceased alive on <u>May 20</u> , 19 <u>62</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1118 St Paul St Baltimore 2, Maryland</u> DATE SIGNED <u>5-21-62</u>							
ACTUAL SIGNATURE <u>John A. Nesbitt, Jr</u>				M.D. <u>1118 St Paul St Baltimore 2, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-23-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickow & Sons</u>				ADDRESS <u>Baltimore 17, Md.</u>		24c. REC'D BY REGISTRAR DATE <u>MAY 24 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm J. Lickow</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

WESTERN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

02123

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05487 CERTIFICATE OF DEATH 05481

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MD b. COUNTY Balto					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto Co		c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto Co		d. STREET ADDRESS 25 Ebenezer Rd		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 25 Ebenezer Road									
3. NAME OF DECEASED (Type or print) First William Middle H Last Howell				4. DATE OF DEATH Month 5 Day 30 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-26-1875		9. AGE (In years last birthday) 87 yrs.	
						IF UNDER 1 YEAR Months 87 Days 87		IF UNDER 24 HRS. Hours 87 Min. 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (County & State, or foreign country) Balto Co. MD		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Howell				14. MOTHER'S MAIDEN NAME Sarah Christopher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Margaret Fritter 25 Ebenezer Rd Balto (20)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardio-Vascular disease (c), stating the underlying cause last. DUE TO 5 yrs								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
21. I certify that (I) (this hospital) attended the deceased from Jun 1 19 62 to 5/29 19 62 , that (I) (we) last saw the deceased alive on 5/29 19 62 , and that death occurred at 8 P.M. from the causes and on the date stated above.									
22a. SIGNATURE G.M. Baumgardner M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/31/62			
22c. PHYSICIAN'S NAME (Type) G.M. BAUMGARDNER				22d. ADDRESS Balto 6 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-1962		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town or county) Chase		(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road (36)				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 1 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1255

12/12

11

1

1-21 1-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN b 13 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 20 d. STREET ADDRESS 9 BUTTERCUP LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRAME J. HUFF		4. DATE OF DEATH Month Day Year MAY 6 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1906
9. AGE (In years and days) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Bridgeport, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND J. HUFF		14. MOTHER'S MAIDEN NAME CECELIA McGRILL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 286-09-0538	
17. INFORMANT CLINICAL RECORDS VAH, FORT HOWARD MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (b) DIABETIC NEPHROPATHY (c) DIABETES MELLITUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 260X	
19. INTERVAL BETWEEN ONSET AND DEATH 1 Month		20. UNKNOWN 13 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 Apr 19 62 , to 6 May 19 62 ; that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 May 19 62 , and that death occurred at 2:15 AM from the causes and on the date stated above.			
22a. SIGNATURE George C. McElPatrick, MD		22b. DATE SIGNED 5/6/62	
22c. PHYSICIAN'S NAME (Type) George C. McElPatrick, MD		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/62	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Kityke Fur. Home, Balt. 29, Md.		25a. REC'D BY REGISTRAR DATE MAY 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Grant			

(M)

BALTIMORE

PORT HOBART

13 Days

BALTIMORE 20

VETERANS ADMINISTRATION HOSPITAL

2 HATTINGUP LANE

SPARE

HIGH

MAY

62

MALE

October 3, 1942

22

Bricklayer

Construction

Bridgeport, Ohio

U.S.A.

RAYMOND J. HUFF

ORCELA MOON III

YES

186-02-0238

CLINICAL RECORDS
VAN, FORT HOWARD HOSPITAL

URINAL

1 Month

DIABETIC HEMIPARESIS

Unknown

DIABETES MELLITUS

13 Years

X

X

62

23 Apr

62

6 May

62 X

5/6/62

DR. C. J. LEAVELLE, JR., M.D.
VAN, FORT HOWARD, HOSPITAL

LOGGON PARK CEMETERY
BALTIMORE, MARYLAND

Interred

MAY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05489 CERTIFICATE OF DEATH 05483

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 1 yr. 5 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS 8401 Leave Street	
3. NAME OF DECEASED (Type or print) Debbie Elaine HUNLEY		4. DATE OF DEATH 5 8 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/58
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Prince Georges Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bethel Vernon Hunley		14. MOTHER'S MAIDEN NAME Shirley Darlena Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Status Epilepticus complicated this - by bilateral bronchopneumonia 4 days -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atonic Oeplgia congenital c Symptomatic Birth		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) Epilepsy -	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from 11/15 , 19 60 , to 5/8 , 19 62 that (H) (we) last saw the deceased alive on 5/8 , 19 62 , and that death occurred at 5:45 p.m. the causes and on the date stated above.			
22a. SIGNATURE Harry G. Butler		22b. DATE SIGNED 5/9/62	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22d. ADDRESS Rosewood Lane, Owings Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-11-1962	23c. NAME OF CEMETERY OR CREMATORY Liberty Baptist	23d. LOCATION (City, town or county) (State) Lisbon, Md
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR MAY 11 '62	
		25b. REGISTRAR'S SIGNATURE Amos S. Kraus	

Liberty Bell 2-11-1962

11:00 AM

Harry E. Foster, Jr.

Postwood Inn, Orange Mills, Maryland

2/8

2/8

11:00 2/8

2/8

x

Robert Vernon Harley

Chief, Bureau, Postwood

Independent

none

Postwood Inn, Orange Mills, Maryland

Postwood Inn, Orange Mills, Maryland

2/8

4

State

2/8

5

62

Postwood Inn, Orange Mills, Maryland

Postwood Inn, Orange Mills, Maryland

1/1/62

Postwood Inn, Orange Mills, Maryland

Postwood Inn, Orange Mills, Maryland

Postwood Inn, Orange Mills, Maryland

Postwood Inn, Orange Mills, Maryland

62-11

62-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY in 1b 9 YRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6158 Regent Park Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 6158 REGENT PK. RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Hush Last Hush		4. DATE OF DEATH May 1/62 Month May Day 1 Year 1962	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 23, 1886 Last 76 yrs.
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER, W.P. DAWSON	11. BIRTHPLACE (County & State, or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HUSH	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 216-07-7871		17. INFORMANT MRS ROBERT C. MOTTI # 6158 REGENT PK. RD. 28 MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V.D. 422.1 Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 56 to May 1, 1962 that (I) (we) last saw the deceased alive on Apr 30, 1962 , and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. C. Pouno M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. C. Pouno		22d. ADDRESS 3325 Frederick av	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/5/62	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	23d. LOCATION (City, town or county) (State) BALTO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR MAY 3 '62	
25b. REGISTRAR'S SIGNATURE Chas. S. Hume			

10-13-34

DEPARTMENT OF HEALTH

10-13-34

Baltimore

M

Catonsville

6188 Robert Ford Rd.

Charles

Irish

May 1/32

March 1934

X

M

Peter J. P. P. P.

M.D.

11-3-34

University

1/31

at 11/11/34

at 11/11/34

at 11/11/34

at 11/11/34

at 11/11/34

at 11/11/34

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
05491											
05485											
Item 1 Film 0313 5/28/62											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>											
c. LENGTH OF STAY IN 1b <u>1 month</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>											
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>											
d. STREET ADDRESS <u>113 Audrey Lane</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>S.</u> Last <u>Jackson</u>											
4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1962</u>											
5. SEX <u>M</u>											
6. COLOR OR RACE <u>W</u>											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
B. DATE OF BIRTH <u>11-12-89</u>											
9. AGE (In years lost birthday) <u>72</u> yrs.											
IF UNDER 1 YEAR Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Retired U.S. Navy Yard N.Y.</u>											
10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u>											
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>											
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>											
13. FATHER'S NAME <u>George D Jackson</u>											
14. MOTHER'S MAIDEN NAME <u>Margaret Bigler</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>											
16. SOCIAL SECURITY NO. <u>577-10-9493A</u>											
17. INFORMANT <u>Rose Jackson</u> Address <u>113 Audrey Lane WASH 21 D.C.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> 19 <u>62</u> to <u>5-20</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>5-20</u> 19 <u>62</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Ricardo Ibanez</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>5-20-62</u>											
22c. PHYSICIAN'S NAME (Type) <u>RICARDO IBANEZ</u>											
22d. ADDRESS <u>Spring Grove Hospital</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIPRA</u>											
23b. DATE THEREOF <u>5-22-62</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN CEM</u>											
23d. LOCATION (City, town, or county) (State) <u>CLARKSBURG WEST, VA.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chomley</u> ADDRESS <u>517-1114 SE WASH DC</u>											
25a. REC'D BY REGISTRAR <u>DATE MAY 23 '62</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

05782

STATE OF CALIFORNIA

1917

(M)

(1)

Blank document with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 935 Bevan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GUY W. JACKSON					4. DATE OF DEATH Month May Day 3 Year 19 62				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1887		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (County & State, or foreign country) Farquare Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Littleton Jackson					14. MOTHER'S MAIDEN NAME Lucy F. Furgeson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I					16. SOCIAL SECURITY NO. 216-07-6702		17. INFORMANT Clinical Records, VA Hospital Fort Howard, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PEPTIC ULCER, LESSER CURVATURE OF STOMACH DUE TO Conditions, if any, which gave rise to immediate cause (b) HEMATEMESIS (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (r) (this hospital) attended the deceased from April 30, 1962 to May 3, 1962 , that (r) (we) last saw the deceased alive on May 3, 1962 , and that death occurred at 11:50AM from the causes and on the date stated above.									
22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, FORT HOWARD, MARYLAND 22b. DATE SIGNED 5/3/62				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-7-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Ct Baltimore, City		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 108 W. Montgomery St					25a. REC'D BY REGISTRAR MAY 7 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume		

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7/11/54

RECEIVED 1954, M. P.

Baltimore National City Baltimore, City

5-7-52

Initial

108 W. Montgomery St

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05493 CERTIFICATE OF DEATH 05487

1. PLACE OF DEATH COUNTY Baltimore County M 02 I b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 11416 Chapel Hill Drive Baltimore 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Janet Ann Jackson		4. DATE OF DEATH Month 5 Day 3 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 31 yrs.
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles (Linn) F. Miles		14. MOTHER'S MAIDEN NAME Anna McElroy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 217-26-5390	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 592X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Chronic Glomerulonephritis INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) a Diabetes mellitus & Pulmonary tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-16 , 19 62 to 5-3 , 19 62 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 , from the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/7/62	
23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City, town or county) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck Inc		25e. REC'D BY REGISTRAR DATE MAY 7 '62	
ADDRESS 5305 HARFORD RD.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

10408

10408

(M)

(1)

Wilson, John

Wilson, John

Charles

Charles - see Murray 191
Wilson, John

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<div style="display: flex; justify-content: space-between;"> 05494 Item 9 Film 6314 6/8/62 iwk 05488 </div>											
1. PLACE OF DEATH a. COUNTY Baltimore Co MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7844 Lockwood Rd.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MONROE Middle JACKSON Last JACKSON						4. DATE OF DEATH Month May Day 31 Year 19 62					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/28/1902		9. AGE (In years last birthday) 59 60 yrs.		IF UNDER 1 YEAR Months 59 Days 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauff.				10b. KIND OF BUSINESS OR INDUSTRY Sun Cab Co				11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) Yes 9/19-5/23						16. SOCIAL SECURITY NO. 9/19-5/23					
17. INFORMANT Pearl Glinowicki 2019 Spark Ct.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO A-S-C-V Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Card Lunging											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE M B Davis M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) M B Davis M D						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 6/1/62						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/4/1962				22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery			
22d. LOCATION (City, town, or country) Baltimore Co. Md.				22e. LOCATION (City, town, or country) Baltimore Co. Md.				22f. LOCATION (City, town, or country) Baltimore Co. Md.			
23. FUNERAL DIRECTOR John M. Weber & Sons Inc 401 S. Chester St.						24a. REC'D BY REGISTRAR JUN 4 '62 DATE					
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

MEDICAL CERTIFICATION

THE STATE
OF CALIFORNIA

(M)

Attorney General

California

1944-1945

1944-1945

1944-1945

1944-1945

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1944-1945

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1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05495

CERTIFICATE OF DEATH

Reg. Dist. No. 05489

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8610 Drumwood Road</i>		d. STREET ADDRESS <i>8610 Drumwood Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Paul</i> Middle <i>T.</i> Last <i>Johnson</i>		4. DATE OF DEATH Month <i>May</i> Day <i>11</i> Year <i>19 62</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 19, 1881</i>
9. AGE (In years lost birthday) yrs. <i>81</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Selma Winzer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212015691</i>	
17. INFORMANT <i>Mrs. Goerge Schroeder</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Hemorrhage - Multiple</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>HTCVD</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i> <i>10+ yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/20, 1961</i> , to <i>5/11, 1962</i> , that I last saw the deceased alive on <i>5/11, 1962</i> , and that death occurred at <i>340 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor F. Zeng</i>		DATE SIGNED <i>5/11/62</i>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/14/62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MORELAND Mem.</i>		22d. LOCATION (City, town, or county) (State) <i>BALTIMORE Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 15 '62</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05496
05490
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings Mills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 195 Painters Mills Rd.		d. STREET ADDRESS Box 195 Painters Mills Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella A. Jones		4. DATE OF DEATH May 12 19 62		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 84 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Thomas Cranmer		14. MOTHER'S MAIDEN NAME Abby Dye		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 213-32-7968		17. INFORMANT Mr. Robert C. Jones - Box 195 Painters Mills Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerosis - generalized (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from March 1962 to May 12 1962, that (I) (we) last saw the deceased alive on May 10 1962, and that death occurred at 4:45 P.M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/16/62 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery 23d. LOCATION (City, town or county) (State) Pikesville, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25c. DATE MAY 14 '62					

VR A15 (4)
15M 9/60

3023

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05497
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 11 mo d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 2 Norman Allen St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George James Kasisky First Middle Last				4. DATE OF DEATH 5 25 1962 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/13/06	
9. AGE (In years) 56 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Kasisky				14. MOTHER'S MAIDEN NAME Mary Franek			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 135-12-7720			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Lar advanced pulmonary tuberculosis 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 2 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dyspnea			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)		20g. (State)		20h. (Country)	
21. I certify that (I) (this hospital) attended the deceased from 6-30 , 19 61 , to 5-26 , 19 62 , that (I) (we) last saw the deceased alive on 5-20 , 19 62 , and that death occurred at 12:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer M.D. 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22b. DATE SIGNED 5/26/62 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 5-29-62				23c. NAME OF CEMETERY OR CREMATORY Immac. Concept. Cem.			
23d. LOCATION (City, town or county) Nr. Elkton, Md.				23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home - Dodd R. De ADDRESS ELKTON MD				25a. REC'D BY REGISTRAR JUN 1 '62			
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus				25c. DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05498
05492
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Aged Mens & Womens Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3401.4 d. STREET ADDRESS 213 S. East Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jennie P Kestner		4. DATE OF DEATH Month May Day 3 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 2	IF UNDER 24 HRS. Hours 2 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY England	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Parvin		14. MOTHER'S MAIDEN NAME Jennie Eliza	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harry E. Hammett, R.N.		Address 6500 E. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart disease (c) Arteriosclerotic Heart disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 10 days Seven years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 1957 to May 3, 1962, that (I) (we) last saw the deceased alive on May 2, 1962, and that death occurred at 5:30 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Newland E. Day M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Newland E. Day, M.D.		22d. ADDRESS 4 East 33rd Street, Baltimore 18, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-5-62	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) 7725 Eastern Avenue	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05493

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Seminole Ave.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Roanoke c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X.3 d. STREET ADDRESS 401 22nd St. S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Zetta D. Kidd		4. DATE OF DEATH Month Day Year May 7, 1962 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1891
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME ----Whorley	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT (daughter) Mrs. James I. Moore, 14 Seminole Ave. Cat. 28	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho - Pneumonia 162.1 DUE TO (b) Cerebral Metastasis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Oat Cell Carcinoma of Rt Lung		INTERVAL BETWEEN ONSET AND DEATH 30 days - One week 9 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov - 1961 , to May 7, 1962 , that (I) (we) last saw the deceased alive on May 7, 1962 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Wetherbee Fort M.D.		22b. DATE SIGNED May 10 '62	
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort		22d. ADDRESS 1118 St. Paul St. - Baltimore 2 - Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 11/62	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville 8, Md.
24a. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Virginia

Roanoke

401 2nd St. S. W.

May 7, 1952

July 11, 1951

Virginia

Unknown

(daughter)

Mrs. James L. Moore, 14 Seminoles Ave., N.W.

Baltimore

Catonsville

14 Seminoles Ave.

John D. Kidd

White

Our home

-----Whorley

Baltimore 8, Md.

May 11/52

14 Seminoles Ave.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05500 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05494

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY in lb 395 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1523 North Bethel Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle King Last King				4. DATE OF DEATH Month 5 Day 21 Year 19 62			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/10	
9. AGE (in years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 21		11. IF UNDER 24 HRS. Hours 19 Min. 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William King				14. MOTHER'S MAIDEN NAME Martha King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-05-3167			
17. INFORMANT Martha King				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) 217-05-3167 Hospital Records, Mt. Wilson State Hosp.							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage, surgical				INTERVAL BETWEEN ONSET AND DEATH 25 minutes			
DUE TO 002.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Uncontrolled hemorrhage during surgery			
DUE TO (c) Pulmonary Tuberculosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Hemorrhage complicating surgical procedure			
20c. TIME OF INJURY Month, Day, Year Hour a.m. None p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D.D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D.D. Caples, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 5/21/62			
				Address (Street, city, town, or county) Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/25/62		22c. NAME OF CEMETERY OR CREMATORY mt Calvary		22d. LOCATION (City, town, or county) (State) Brooklyn Md	
23. FUNERAL DIRECTOR Erroy O. Wilson 1100 Beantley Ave				24a. REC'D BY REGISTRAR DATE MAY 25 '62		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

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MEDICAL EXAMINATION REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05501
05445
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> c. LENGTH OF STAY IN lb <u>27 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hunter Mill Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> d. STREET ADDRESS <u>Hunter Mill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl L. Larrick</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Winchester, Va.</u>	
13. FATHER'S NAME <u>George Womel dorph</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bayliss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Kingel J. Larrick, White Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9:20</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> 19 <u>62</u> to <u>May 21</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> 19 <u>62</u> , and that death occurred at <u>4:47</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u> M.D.		22b. DATE SIGNED <u>5/22/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 24, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Shoeb Gartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
25b. REGISTRAR'S SIGNATURE		25c. LOCATION (City, town or county) (State) <u>Winchester, Va.</u>	

40-00

CHARTER OF 1825

1825



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
05502									
05496									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb 40 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7507 Brightside Avenue					d. STREET ADDRESS 7507 Brightside Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY L. LETTOW					4. DATE OF DEATH May 23 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-1896		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Airreduction Sales		11. BIRTHPLACE (State or foreign country) Harford Co Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Heinreich Lettow					14. MOTHER'S MAIDEN NAME Katherine Weil				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW #1					16. SOCIAL SECURITY NO. 215-01-0243		17. INFORMANT Mrs Charolette Mc Cann 11 Geranium Place		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured myocardial infarct DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) Baltimore		20g. (County) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-23-62									
ACTUAL SIGNATURE R. Breitenecker		EXAMINER'S NAME (Type) R. Breitenecker, M.D.		Address (Street, city, town, or county) Baltimore Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-1962		22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland			
23. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Road		24a. REC'D BY REGISTRAR MAY 25 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05503

CERTIFICATE OF DEATH

05497

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital		d. STREET ADDRESS 3010 SPRUDDING AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ELLICK LIGHTNER		4. DATE OF DEATH Month Day Year MAY 29 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4 1899
9. AGE (In years, last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY BOLT AND NUT CO	
11. BIRTHPLACE (County & State, or foreign country) HANOVER PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HAMILTON W. LIGHTNER		14. MOTHER'S MAIDEN NAME ANNIE REIBERT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-20-6314	
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) PULMONARY TUBERCULOSIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3/7/60 to 5/29/62, that (I) (we) last saw the deceased alive on 5/29/62, and that death occurred at 5:30 P.M. from the causes and on the date stated above. 22a. SIGNATURE W. Newcomer 22b. DATE SIGNED 5/29/62 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 6-2-62	
23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson 4		25a. REC'D BY REGISTRAR DATE JUN 1 '62	
		25b. REGISTRAR'S SIGNATURE Wm. L. Frank	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05504										
05498										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 430 Woodbine Ave					d. STREET ADDRESS 430 Woodbine Ave					
3. NAME OF DECEASED (Type or print) First ALFRED Middle SAMUEL Last LOIZEAUX					4. DATE OF DEATH May 7, 1962 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1877		9. AGE (In years last birthday) 85 yrs.		
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer					10b. KIND OF BUSINESS OR INDUSTRY Gas & Elect. Co. Iowa					
11. BIRTHPLACE (County & State, or foreign country) Iowa					12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Timothy O. Loizeaux					14. MOTHER'S MAIDEN NAME Anne M. Roberts					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 212-05-6581					
17. INFORMANT A. Milton Loizeaux					Address 430 Woodbine Ave, 4					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (was hospital) attended the deceased from July 10, 1960 to May 7, 1962 ; that (I) (was) last saw the deceased alive on May 7, 1962 , and that death occurred at 2:22 P.M. from the causes and on the date stated above. 22a. SIGNATURE Dr. Laurence C. Post M.D. 22b. DATE SIGNED 5/7/62 22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post 22d. ADDRESS 6805 York Road, Baltimore 12, Md. 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/10/62		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24 FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.					ADDRESS York Rd. Towson 4, Md.					
25a. REC'D BY REGISTRAR May 9 '62					25b. REGISTRAR'S SIGNATURE Charles L. Hines					



Am Book-Town, Inc., New York, N.Y. + 1000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> c. LENGTH OF STAY IN 1b <u>40yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1121 Maiden Choice Rd</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>1121 Maiden Choice Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Henry Mack</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vegetable</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Gustav Mack</u>					
14. MOTHER'S MAIDEN NAME <u>Mary Schwab</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>John Mack</u> Address <u>1121 Maiden Choice Rd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> About <u>10 years</u> DUE TO (b) <u>Old age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Cystitis</u> About <u>6 weeks</u> <u>Enlarged prostate</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 26,</u> 19 <u>62</u> , to <u>May 6,</u> 19 <u>62</u> that (I) <u>(we)</u> last saw the deceased alive on <u>May 5,</u> 19 <u>62</u> , and that death occurred at <u>2 a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest G. Marr</u> M.D.			22b. DATE SIGNED <u>May 7, 1962</u>				
22c. PHYSICIAN'S NAME (Type) <u>Ernest G. Marr</u>			22d. ADDRESS <u>516 Cathedral St Baltimore, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/8/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery Baltimore, Maryland</u>			
23d. LOCATION (City, town or county) <u>Baltimore</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrice, Inc. 1328 Saltyeon Spring Rd</u>			ADDRESS				
25a. REC'D BY REGISTRAR <u>MAY 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thayer</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DATA

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Handwritten notes and signatures, including "J. Edgar Hoover" and "F. B. I."

Handwritten notes and signatures, including "J. Edgar Hoover" and "F. B. I."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05506 CERTIFICATE OF DEATH 05500

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. 12	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO. 12		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 124 Overbrook Rd.		d. STREET ADDRESS 124 OVERBROOK RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle M. Last MANNING		4. DATE OF DEATH Month MAY Day 26 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 25, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JACOB BURKART		14. MOTHER'S MAIDEN NAME ELIZABETH REICHLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease with Decompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 50 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 19 1960 to MAY 19 1962 , that (I) (we) last saw the deceased alive on MAY 14 1962 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm H. Kommer, Jr. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Wm H. Kommer, Jr.		22b. DATE SIGNED 5/28/62	
22d. ADDRESS 8011 York Rd. Balto. 12, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 29, 1962	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		23d. LOCATION (City, town or county) (State) BALTO., MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		ADDRESS	
25a. REC'D BY REGISTRAR JUN 1 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Kinner	

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JAMES BURKART

FEMALE WHITE

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ELIZABETH REICHEY

FAMILY RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05507 CERTIFICATE OF DEATH 05501

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyde, Md				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Road				d. STREET ADDRESS York Road			
3. NAME OF DECEASED (Type or print) Thomas Floyd Massey				4. DATE OF DEATH May 19 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1896	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		10b. KIND OF BUSINESS OR INDUSTRY Dock Work		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Massey				14. MOTHER'S MAIDEN NAME Ida (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I 219-01-4155		17. INFORMANT Ida May Goldberg, Beaver Dam Road, Cockeysville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1962 to May 17, 1962 , that (I) (we) last saw the deceased alive on May 17, 1962 , and that death occurred at 2:38 AM , from the causes and on the date stated above.							
22a. SIGNATURE William A. Tyson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-19-62	
22c. PHYSICIAN'S NAME (Type) William A. Tyson				22d. ADDRESS Hingsville Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-23-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore, National		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. 1050 York Road, Towson				25a. REC'D BY REGISTRAR MAY 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

Baltimore

Harrisburg, Pa.
Harrisburg, Pa.

Harrisburg, Pa.
Harrisburg, Pa.

for information
Harrisburg, Pa.

Book and
Harrisburg, Pa.

via
Harrisburg, Pa.

via
Harrisburg, Pa.

DURHAM
2-22-82

Baltimore, National

Mr. Cook - London, Inc. 1050 York Road, Towson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after the date of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>900 S. Sharp Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWIN E. McCLAIN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 14, 1933</u> 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber Mfg. Company</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas McClain</u>		14. MOTHER'S MAIDEN NAME <u>Dora Waters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes PL-28</u>		16. SOCIAL SECURITY NO. <u>215-30-4073</u>	
17. INFORMANT <u>Clinical Records, VA Hospital, Fort Howard Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIABETIC ACIDOSIS</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>DIABETIC MELLITUS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>U</u> (this hospital) attended the deceased from <u>May 15, 1962</u> to <u>May 16, 1962</u> that <u>(X)</u> (we) last saw the deceased live on <u>May 16, 1962</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Irving Freeman</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5/17/62	
22c. PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M. D.</u>		22b. ADDRESS <u>VAH Fort Howard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat Cem</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1000 Brontley Ave</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 24 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Clifford L. Thomas</u>	

(M)

(T)

17-508

00508

CHRONOLOGICAL INDEX

1917-1918

1919-1920

1921-1922

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1935-1936

1937-1938

1939-1940

1941-1942

1943-1944

1945-1946

1947-1948

1949-1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
Baltimore 05509
05509
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY GARRISON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxleigh convalesc. Home c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Elba J. McConnell		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 614 Cliveden Rd. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elba J. McConnell		4. DATE OF DEATH 5 - 17 - 1962	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1895
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher School		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wilkes-Barre, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James J. Farrell		14. MOTHER'S MAIDEN NAME CATHERINE MEEHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL PNEUMONIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) GENERALIZED ARTERIOSCLEROSIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/10/61 to 5/17/62 , that (I) last saw the deceased alive on 5/17/62 and that death occurred 5/17/62 from the causes and on the date stated above.			
22a. SIGNATURE Samuel P. Scalia M.D.		22b. DATE SIGNED 5-17-62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS PIKESVILLE 8, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	5-22-62	St. Marys - (Hanover Township)	Wilkes-Barre, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Newell		25a. REC'D BY REGISTRAR May 21 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

(M)

RECEIVED
JAN 10 1900

TO THE
HONORABLE
SIR
THE
OFFICE OF THE
SOLICITOR GENERAL
LONDON
FROM
JAMES H. HARRIS
ESQ.
OF THE
FIRM OF
HARRIS & HARRIS
SOLICITORS
15, ABchurch Lane, E.C. 4

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the above matter.
I am sorry to hear that you are unable to attend to the matter at present, but I shall be glad to hear from you again when you are able to do so.
Very respectfully,
JAMES H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05510

05504

1. PLACE OF DEATH e. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 106 MELVIN AVE		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 106 MELVIN AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH L. MENNERICK SR.		4. DATE OF DEATH Month Day Year MAY 18, 1962	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 14, 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GAS FITTER, GAS & ELECTRIC CO.		12. KIND OF BUSINESS OR INDUSTRY MD.	
13. FATHER'S NAME HERMAN L. MENNERICK		14. MOTHER'S MAIDEN NAME HARRIETT C. HIGDON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 25-03-0332	
17. INFORMANT MRS ALICE MENNERICK		18. ADDRESS 106 MELVIN AVE, CATONSVILLE 28, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO CORONARY OCCLUSION (c) 420.1 DUE TO CORONARY OCCLUSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL HEMORRHAGE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. INTERVAL BETWEEN ONSET AND DEATH 10 MIN.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-3 , 19 53 , to 5-18 , 19 62 , that (I) (we) last saw the deceased alive on 5-12 , 19 62 , and that death occurred at 10 A. from the causes and on the date stated above.			
22a. SIGNATURE John F. Schaefer M.D.		22b. DATE SIGNED 5/19/62	
22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER		22d. ADDRESS 401 RANDOM RD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/21/62	
23c. NAME OF CEMETERY OR CREMATORY WESTERN CEMT.		23d. LOCATION (City, town or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE ADDRESS 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR MAY 21 '62	
25b. REGISTRAR'S SIGNATURE Arthur J. Mauer			

1990

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

05511

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05505

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in The Pines</u>		d. STREET ADDRESS <u>3207 W. Starthmore Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>MERIN</u> Last <u>1879</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Florence Wolfe-7425 Ricksway Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>42011</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> 19 <u>62</u> to <u>5-13</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>5-13</u> 19 <u>62</u> and that death occurred <u>at 4:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>5-14-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		22d. ADDRESS <u>6209 Frederick Rd, Bt 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 14/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beth Jacob</u>		23d. LOCATION (City, town, or county) (State) <u>Finksburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levinson & Bros, Inc 6010 Reisterstown Road</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05512 CERTIFICATE OF DEATH 05506											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2540 Liberty Parkway						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2540 Liberty Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Thomas Albah Boyd Merritt			4. DATE OF DEATH May 25 19 62			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Feb. 2, 1892			9. AGE (In years last birthday) 70			10. IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Tax Assessor)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Co., Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James A. Merritt						14. MOTHER'S MAIDEN NAME Ella J. Graves					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO.					
17. INFORMANT Mrs. Helen Mc Kay Merritt-2540 Liberty PKWY						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung. 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the hospital) attended the deceased from Feb 6 1962 to May 25 1962 , that (I) (wa) last saw the deceased alive on May 15 1962 , and that death occurred May 25 1962 from the causes and on the date stated above. 22a. SIGNATURE M. B. Davis M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) M. B. DAVIS M.D. 22d. ADDRESS 6800 Mornington Road - 22											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-28-62		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery				23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons						25a. REC'D BY REGISTRAR MAY 29 '62					
ADDRESS Balto. 17, Md.						25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 13, Film G-314 6/1/62. cac.

1. NAME OF DECEASED
(Type or Print)

MERRYMAN, STEPHEN W.

2. DATE OF DEATH

5/9/62

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore County
8826 Liberty Rd.
Randallstown, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE B. COUNTY

MD.

Balt.

C. CITY OR TOWN

(If outside city limits write RURAL and give township)

XRANDALLSTOWN

D. STREET ADDRESS

(If rural give location)

18826 LIBERTY RD

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

2/2/46

9. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Marvin Merryman, Jr.

14. MOTHER'S MAIDEN NAME

ELIZ. LAMBORN LAMBORN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) NO

(If yes give war or dates of service)

16. SOCIAL
SECURITY NO

NONE

17. INFORMANT

ADDRESS

ELIZABETH L. MERRYMAN SAME

18. I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

201X

CAUSE OF DEATH

HODGKIN'S DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

5 YRS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, WAS THE DECEASED ATTENDED BY THE DECEASED FROM

1958

1962, that (I) (we) last saw the deceased alive on

5/9/62

and that in (my) (our) opinion death occurred at 5:45 P. M. from the causes and on the date stated above.

23A. SIGNATURE

David Sulman

23B. ADDRESS

University Hospital

23C. DATE SIGNED

5/9/62

24A. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

5-11-62

24C. NAME OF CEMETERY or CREMATORY

FRIENDS BURIAL GROUND BALTO. MD.

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 11 '62

25B. NAME OF REGISTRAR

Charles A. Smith

25C. FUNERAL DIRECTOR

JOHN C. MITCHELL & SONS, INC. 1900 D

ADDRESS

(M)

1. NAME OF DEATH
A. COUNTY

2. SEX (MALE/FEMALE)

3. DATE OF BIRTH (Month/Day/Year)

4. PLACE OF BIRTH (City/Town/Village)

5. NAME OF HUSBAND OR WIFE (Last/First/Middle)

6. OCCUPATION (Type of work)

7. EDUCATION (Grade completed)

8. RELIGION (If any)

9. RACE OR ETHNICITY (If any)

10. DATE OF DEATH (Month/Day/Year)

11. PLACE OF DEATH (City/Town/Village)

12. CAUSE OF DEATH (If known, state cause and manner of death)
13. MANNER OF DEATH (If known, state manner of death)
14. TIME OF DEATH (If known, state time of death)

15. NAME OF PHYSICIAN (If any)

16. NAME OF HUSBAND OR WIFE (Last/First/Middle)

17. NAME OF HUSBAND OR WIFE (Last/First/Middle)

18. NAME OF HUSBAND OR WIFE (Last/First/Middle)

19. NAME OF HUSBAND OR WIFE (Last/First/Middle)

20. NAME OF HUSBAND OR WIFE (Last/First/Middle)

21. NAME OF HUSBAND OR WIFE (Last/First/Middle)

22. NAME OF HUSBAND OR WIFE (Last/First/Middle)

23. NAME OF HUSBAND OR WIFE (Last/First/Middle)

24. NAME OF HUSBAND OR WIFE (Last/First/Middle)

25. NAME OF HUSBAND OR WIFE (Last/First/Middle)

26. NAME OF HUSBAND OR WIFE (Last/First/Middle)

27. NAME OF HUSBAND OR WIFE (Last/First/Middle)

28. NAME OF HUSBAND OR WIFE (Last/First/Middle)

29. NAME OF HUSBAND OR WIFE (Last/First/Middle)

30. NAME OF HUSBAND OR WIFE (Last/First/Middle)

31. NAME OF HUSBAND OR WIFE (Last/First/Middle)

32. NAME OF HUSBAND OR WIFE (Last/First/Middle)

33. NAME OF HUSBAND OR WIFE (Last/First/Middle)

34. NAME OF HUSBAND OR WIFE (Last/First/Middle)

35. NAME OF HUSBAND OR WIFE (Last/First/Middle)

36. NAME OF HUSBAND OR WIFE (Last/First/Middle)

37. NAME OF HUSBAND OR WIFE (Last/First/Middle)

38. NAME OF HUSBAND OR WIFE (Last/First/Middle)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05514 CERTIFICATE OF DEATH 05508

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2525 Wentworth Road</i>		d. STREET ADDRESS <i>2525 Wentworth Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Minnie P. Meyer</i>		4. DATE OF DEATH Month Day Year <i>May 7th 19 62</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 20, 1885</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wilhelm Paul</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Mildred Metzger</i>		Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6:16</i> , 19 <i>61</i> , to <i>5:15</i> , 19 <i>62</i> that (I) (we) last saw the deceased alive on <i>5:5</i> , 19 <i>62</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5.7.62</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL. (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/9/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck Inc.</i>		ADDRESS <i>5305 Hafford Rd.</i>	
25a. REC'D BY REGISTRAR DATE <i>MAY 9 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2, 3, and 4 may be retained by the hospital or attending physician. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY in lb several Mo's d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bent Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1813 N. Caroline Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Russell Mickens (Michie) First Middle Last		4. DATE OF DEATH May 25, 1962 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 13, 1893
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Charlottesville, Va.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Thomas Mickens	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 213-09-0263		17. INFORMANT Mr. William L. Waller 1813 N. Caroline St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis - generalized (c) 10 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 10, 1962 to May 23, 1962 , that (I) (we) last saw the deceased alive on May 25, 1962 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Clarence E. McEllean M.D.		22b. DATE SIGNED May 25, 1962	22c. PHYSICIAN'S NAME (Type) Reisterstown Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 29, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson Inc. Morton & Dyett 916 Penna. Ave.		25a. REC'D BY REGISTRAR MAY 28 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kline

00312

00312



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bassetts Nursing Home 235 Bloomsburg Ave.		d. STREET ADDRESS 2609 Hampden Ave.	
3. NAME OF DECEASED (Type or print) Eva M. Miller		4. DATE OF DEATH 5-22-1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-1874
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kling		14. MOTHER'S MAIDEN NAME Ewald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *	
INFORMANT Address Balto. Md.		Vernon Miller 2609 Hampden Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio-Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 da. 15 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-12-1961 , to 5-22, 1962 that I last saw the deceased alive on 5-21, 1962 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		M.D. 6209 Frederick Ave. DATE SIGNED 5/28/62	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		Baltimore-28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-26-1962	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Seitz		ADDRESS 814 W. 36th. Baltimore 11, Md.	
VS A15 (4) 15M 9/58		REC'D BY REGISTRAR MAY 25 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05511
05511

1. PLACE OF DEATH a. COUNTY BALTO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUMMIT NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS ESPLANADE APT. HOUSE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle MILLER Last MILLER		4. DATE OF DEATH Month MAY Day 24 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 14, 1904
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 10	IF UNDER 24 HRS. Hours 14 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		10b. KIND OF BUSINESS OR INDUSTRY Doctors office	
11. BIRTHPLACE (County & State, or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Miller		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Mann - Rh - York, Penn.		Address ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Hemiplegic left + complete Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Coronary Artery Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Postoperative of Cardiac Standstill			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour --- a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 62 to 5/24/62 , that (I) (we) last saw the deceased alive on 5/24/62 , and that death occurred 7:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W.E. McGrath		22b. DATE SIGNED 5/25/62	
22c. PHYSICIAN'S NAME (Type) W.E. McGrath		22d. ADDRESS 1303 Frederick Rd Catonsville 28md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-25-62	
23c. NAME OF CEMETERY OR CREMATORY Greenfield Hall Cem.		23d. LOCATION (City, town or county) (State) York, Penn.	
24. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home - Catonsville, Md		25a. REC'D BY REGISTRAR MAY 28 62	
ADDRESS ---		25b. REGISTRAR'S SIGNATURE Arthur S. Krane	

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Photographs of various objects

Handwritten notes, possibly a list or description of items, including phrases like "Handwritten", "Photographs of", and "Handwritten".

Handwritten notes, possibly a list or description of items, including phrases like "Handwritten", "Photographs of", and "Handwritten".

Handwritten notes, possibly a list or description of items, including phrases like "Handwritten", "Photographs of", and "Handwritten".

CERTIFICATE OF DEATH

05512

Reg. Dist. No.

05518

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2604 Wentworth Road</i>		d. STREET ADDRESS <i>2604 Wentworth Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Lillian Mae Moberly</i>		4. DATE OF DEATH Month Day Year <i>May 4, 19 62</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 30, 1879</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis Sinn</i>		14. MOTHER'S MAIDEN NAME <i>MARY Childs</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Mr. Richard C. Moberly, Sr. same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Lung</i> DUE TO (b) <i>Primary Carcinoma of Bladder</i> DUE TO (c) <i>181.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>OCT 4, 1960</i> to <i>MAY 4, 1962</i> that I last saw the deceased alive on <i>MAY 1, 1962</i> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell M.D.</i>		ADDRESS (Street, city or town, state) <i>2501 York Rd</i>	
PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell M.D.</i>		DATE SIGNED <i>5/4/62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/7/62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MORELAND MEM. BALTIMORE</i>		22d. LOCATION (City, town, or county) (State) <i>Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck Inc</i>		ADDRESS <i>5305 Harford Road.</i>	
24a. REC'D BY REGISTRAR <i>MAY 7 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8373

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

8373



[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Place of Death, and Cause of Death. There are also sections for the attending physician and the funeral home. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

CERTIFICATE OF DEATH

Reg. Dist. No.

05519

05513

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oaklyn 67X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs Taylor's Rest Home				d. STREET ADDRESS 206 White Horse Pike			
3. NAME OF DECEASED (Type or print) First GEORGE Middle MORGAN Last				4. DATE OF DEATH Month MAY Day 7 Year 1962 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1891	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Selfemployed				10b. KIND OF BUSINESS OR INDUSTRY West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Morgan				14. MOTHER'S MAIDEN NAME Unknown Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?				16. SOCIAL SECURITY NO. 213 05 6218			
17. INFORMANT Mrs Myrtle R. Kolb				Address Towson # 4 1648 Mussula Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Gen. Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Instant 4 yrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus-Diabetic Gangrene							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 11) Lt. big toe.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-5-1962 to 5-7-1962 that I last saw the deceased alive on 5-5-1962 and that death occurred at 6:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert H. Siver				ADDRESS (Street, city or town, state) 3105 N. Charles St. Baltimore, 18.			
DATE SIGNED 5-7-62							
PHYSICIAN'S NAME (Type) Robert H. Siver M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/11/62		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.				24a. REC'D BY REGISTRAR DATE MAY 10 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

1919

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister of the Gospel

Signature of Undertaker

Signature of Burial Officer

Signature of Cemetery Superintendent

Signature of Health Officer

Signature of Medical Examiner

Signature of Pathologist

Signature of Anatomist

Signature of Surgeon

Signature of Dentist

Signature of Pharmacist

Signature of Dispensing Doctor

Signature of Apothecary

Signature of Chemist

Signature of Druggist

Signature of Apothecary

Signature of Chemist

Signature of Druggist

Signature of Apothecary

Signature of Chemist

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Signature of Apothecary

Signature of Chemist

Signature of Druggist

Signature of Apothecary

Signature of Chemist

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
05520
05514
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TIMONIUUM c. LENGTH OF STAY IN 1b 12 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26 NORTHWOOD DRIVE				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X TIMONIUUM d. STREET ADDRESS 26 NORTHWOOD DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILHELMINA (Minna) KATHERINE (Miller) MUELLER				4. DATE OF DEATH MAY 20 1962			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY HILFEMAN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. MRS. CLIFT, 26 NORTHWOOD DRIVE, TIMONIUUM			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 MONTH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 5 , 19 62 to MAY 20 , 19 62 ; that (I) (we) last saw the deceased alive on MAY 18 , 19 62 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William A. Pillsbury				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-20-62	
22c. PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY				22d. ADDRESS 760 York Rd, Timonium, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-23-62		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) 2930 Frederick Ave, Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road TOWSON 4				25a. REC'D BY REGISTRAR MAY 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1994



22

1999

53-55-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05521 CERTIFICATE OF DEATH 05515

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 729 YORK ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 729 YORK ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle MARY Last MURDOCK		4. DATE OF DEATH Month MAY Day 7 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 31, 1872
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9c. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) IRELAND
13. FATHER'S NAME SAMUEL P. CORBISHLEY		14. MOTHER'S MAIDEN NAME FRANCIS KINEEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO (b) Generalized Arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Cardio Renal Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 12 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Charles F O'Donnell		22b. DATE SIGNED 5/8/62	
22c. PHYSICIAN'S NAME (Type) Charles F O'Donnell		22d. ADDRESS 7501 York Rd Towson Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 9, 1962	
23c. NAME OF CEMETERY OR CREMATORY FRIENDSHIP METHODIST		23d. LOCATION (City, town or county) (State) FALLSTON, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		25a. REC'D BY REGISTRAR DATE MAY 14 '62	
ADDRESS Towson, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

10012

RECEIVED

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05516

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in The Pines</u>		d. STREET ADDRESS <u>1005 HARTMONT Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Angley</u> Middle <u>G.</u> Last <u>Nash</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O RR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HOWARD Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>P. NASH</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>705-05-9576</u>	
17. INFORMANT <u>JACK NASH (SON)</u>		Address <u>1005 HARTMONT Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Hypertensive Cardiovascular Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>13 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-2-</u> 19 <u>49</u> to <u>5-19</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>5-18</u> 19 <u>62</u> and that death occurred at <u>6 P.</u> -M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u> M.D.		22b. DATE SIGNED <u>5/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		22d. ADDRESS <u>6309 Frederick Ave, Balt. 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL Cem</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E S Mac Nabb</u>		25a. REC'D BY REGISTRAR <u>301 Frederick Ave #28</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		25c. DATE <u>MAY 23 '62</u>	

05518

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Chowdhury, K. K. (1911-1912)

1918

William K. Gallagher

William K. Gallagher

East London, 1911-1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05517

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY in lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 180 Baltimore Ave.		d. STREET ADDRESS 180 Baltimore Ave.,	
3. NAME OF DECEASED (Type or print) First Middle Last Brian Craig Nauman		4. DATE OF DEATH Month Day Year May 28, 1962 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 20, 1961
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eulys E. Nauman		14. MOTHER'S MAIDEN NAME Beverly E. Hatch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Eulys E. Nauman, 180 Baltimore Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> <i>Branchopneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral palsy</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>March, 1961</i> to <i>May 28, 1962</i> , that (I) (we) last saw the deceased alive on <i>May 26, 1962</i> and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Herbert J. Levickas</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Herbert J. Levickas</i>		22d. ADDRESS <i>5305 East Ave Balto-27 Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>5/30/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore Maryland</i>
24 FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i>		25a. REC'D BY REGISTRAR <i>MAY 31 1962</i>	
ADDRESS <i>4107 Wilkens Ave. Balto. 29, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur J. ...</i>	

VR A15 (4)
15M 9/60

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Central College

Howard A. Robbins, 407
1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05518

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6920 Sollers Point Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 6920 Sollers Point Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLA M. NELSON		4. DATE OF DEATH May 19 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1897
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles W. Rhinehart	
14. MOTHER'S MAIDEN NAME Rose B. Allen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Oscar A. Nelson 6920 Sollers Point Road-22	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 19 1962 to May 19 1962 ; that (I) (we) last saw the deceased alive on May 19 1962 , and that death occurred at 7 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Stephen C. Mackowiak M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stephen C. Mackowiak, M.D.		22d. ADDRESS 6714 Holston Ave Baltimore Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 23, 1962	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR MAY 22 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

81208

81208

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

05519
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05519

1. PLACE OF DEATH e. COUNTY <i>Balto</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Essex</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>710 Eastern Blvd</i>			d. STREET ADDRESS <i>710 Eastern Blvd</i>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>NATIE CATHERINE NELSON</i>			4. DATE OF DEATH Month Day Year <i>May 20 1962</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 27-1882</i>	9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS.) <i>80</i> yrs. Months Days Hours Min.	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Henry Halmuth</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Anna Bode</i> Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>17-S-C-V-Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>X None</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>M.B. Davis</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>M.B. Davis MD</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>5-23-62</i>		
22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>			22d. LOCATION (City, town, or country) (State) <i>Balto. Co. Md</i>		
24. FUNERAL DIRECTOR <i>John G. Connolly - 418 Eastern Ave.</i>			24a. REC'D BY REGISTRAR <i>JUN 6 '62</i>		
ADDRESS			24b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>		

FILM#314 - THIS WAS REPORTED

ON REGULAR DEATH CERTIFICATE.

6/6/62 - MB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05526

CERTIFICATE OF DEATH

05520

1. PLACE OF DEATH e. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>202 HILTON AVE.</u>		d. STREET ADDRESS <u>202 HILTON AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HILDA EMILY ODIN</u>		4. DATE OF DEATH Month Day Year <u>May 4 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 26, 1880</u>
9. AGE (In years last birthday) <u>81 yrs.</u>		10. IF UNDER 1 YEAR Months Days <u>81</u>	
11. IF UNDER 24 HRS. Hours Min. <u>81</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SWEDEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Lund Kalin</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Mr. Harry Oton 202 Hilton Ave.</u>	
17. INFORMANT <u>Mr. Harry Oton 202 Hilton Ave.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pt. Hemiplegia</u> <u>334X</u> DUE TO <u>Cerebral Vascular Heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis</u> (c) <u>Arterio Sclerosis</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>8 days -</u> <u>year -</u> <u>year -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 14, 1962</u> to <u>May 4, 1962</u> that (I) (we) last saw the deceased alive on <u>May 2, 1962</u> and that death occurred at <u>8:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wetherbee Fort</u>		22b. DATE SIGNED <u>May 4 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>		22d. ADDRESS <u>6 Sutton Ave. Catonsville 26.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>5-7-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Hastings on Hudson, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 10 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

1853

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(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05527												05521																	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles ✓																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						c. LENGTH OF STAY IN 1b 16 dyas						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Maryland 08x2																	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL												d. STREET ADDRESS NO STREET						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First James Middle Lee Last Padgett												4. DATE OF DEATH Month May Day 3 Year 19 62																	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> unknown WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1878, April 21		9. AGE (In years lost birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Farmer -Retired Farming						10b. KIND OF BUSINESS OR INDUSTRY unknown						11. BIRTHPLACE (State or foreign country) unknown Maryland						12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME unknown James T. Padgett												14. MOTHER'S MAIDEN NAME unknown Martha M. Albrittitan																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. unknown						17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)											
21. I certify that 10 (this hospital) attended the deceased from April 9, 1962 to May 3, 1962 , that (I) (we) last saw the deceased alive on May 3, 1962 and that death occurred at 2:35 A.M. from the causes and on the date stated above.																													
22a. SIGNATURE Stella Wachsler M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5-3-62 22b. DATE SIGNED																	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D,												22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 5/5/1962						23c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemeter						23d. LOCATION (City, town, or county) (State) La Plata, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Archant Funeral Home, Inc. La Plata, Md.												ADDRESS						25a. REC'D BY REGISTRAR MAY 8 '62						25b. REGISTRAR'S SIGNATURE Arthur S. Harris					

1500

CERTIFICATE OF BIRTH

1900



1, April 1900

1, April 1900

1, April 1900

1, April 1900

1, April 1900

1, April 1900

1, April 1900

1, April 1900

1, April 1900

1, April 1900

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PIKESVILLE				c. LENGTH OF STAY IN 1b 10 YRS				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X PIKESVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 733 MILFORD MILL RD						d. STREET ADDRESS 733 MILFORD MILL RD					
3. NAME OF DECEASED (Type or print) First DONALD Middle EDWARD Last PEARCE						4. DATE OF DEATH Month MAY Day 4 Year 1962					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-9-05		9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSESSOR						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE C. PEARCE						14. MOTHER'S MAIDEN NAME BLANCHE CHENOWETH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II						16. SOCIAL SECURITY NO. 220-20-6138		17. INFORMANT Address EDITH C. PEARCE, 733 MILFORD MILL RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE William A. Pillsbury M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) William A. Pillsbury DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 2060 York Rd Timonium, Md. 5-4-62											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1962		22c. NAME OF CEMETERY OR CREMATORY St. Thomas				22d. LOCATION (City, town, or country) (State) OWINGS MILLS, MD.			
23. FUNERAL DIRECTOR ADDRESS J.F.Eline & Sons, #4 Reisterstown, Md.						24a. REC'D BY REGISTRAR DATE MAY 7 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

55200

DEPARTMENT OF THE ARMY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1962

DATE OF DEATH
1962

(M)

(I)

U.S. Line & Sons, W. Washington, Md.
May 7, 1962
J. L. Line & Sons, W. Washington, Md.

05529

05523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 18		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland				d. STREET ADDRESS 506 E. 42d. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle L. Last PENN				4. DATE OF DEATH Month 5 Day 9 Year 1962			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-1902	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Harry W. Penn Sr.				14. MOTHER'S MAIDEN NAME Cora E. Hickenbotham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-07-8070		17. INFORMANT Personal History Address Hospital Records, Eudowood Sanatorium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 016X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENITO-URINARY TUBERCULOSIS app 18 yrs (c) app 18 yrs						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1 19 61 , to 5-9 19 62 , that I lost s/he the deceased alive on 5-6 19 62 , and that death occurred at 1:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jorge C. Rovetti				ADDRESS (Street, city or town, state) Medical Arts Bldg, Balto 1			
PHYSICIAN'S NAME (Type) Bennett Steen, M.D.				Eudowood Sanatorium, Towson 4, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		May 10 1962		Lawson Park		Baltimore 29-MD	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart Wilson				ADDRESS 10840 North Ave		24a. REC'D BY REGISTRAR DATE MAY 11 '62	
				24b. REGISTRAR'S SIGNATURE Anthony J. H...			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLDOSE 18

10-1-22

PART I. A.

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Date of birth: [illegible]

4. Place of birth: [illegible]

5. Usual residence: [illegible]

6. Date of death: [illegible]

7. Time of death: [illegible]

8. Cause of death: [illegible]

9. Place of death: [illegible]

10. Signature of physician: [illegible]

11. Signature of registrar: [illegible]

12. Signature of informant: [illegible]

13. Signature of funeral director: [illegible]

14. Signature of undertaker: [illegible]

15. Signature of coroner: [illegible]

16. Signature of justice: [illegible]

17. Signature of clerk: [illegible]

18. Signature of registrar: [illegible]

19. Signature of informant: [illegible]

20. Signature of funeral director: [illegible]

21. Signature of undertaker: [illegible]

22. Signature of coroner: [illegible]

23. Signature of justice: [illegible]

24. Signature of clerk: [illegible]

25. Signature of registrar: [illegible]

26. Signature of informant: [illegible]

27. Signature of funeral director: [illegible]

28. Signature of undertaker: [illegible]

29. Signature of coroner: [illegible]

30. Signature of justice: [illegible]

31. Signature of clerk: [illegible]

32. Signature of registrar: [illegible]

33. Signature of informant: [illegible]

34. Signature of funeral director: [illegible]

35. Signature of undertaker: [illegible]

36. Signature of coroner: [illegible]

37. Signature of justice: [illegible]

38. Signature of clerk: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05530

CERTIFICATE OF DEATH

05524

Item 2 Film G312 5/14/62 mb

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LUTHERVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9 THORNFIELD RD			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WATERFORD d. STREET ADDRESS 10 Lloyd Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES PETRAN			4. DATE OF DEATH Month Day Year MAY 4, 1962		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 4 1866	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman - Retired		10b. KIND OF BUSINESS OR INDUSTRY Presby. Minister		11. BIRTHPLACE (County & State, or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wenzel Petran			
14. MOTHER'S MAIDEN NAME Elizabeth Fagel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Family Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 YRS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
2Df. (City or town)		2Dg. (County)		2Dh. (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/28 1962 to MAY 4 1962 that (I) (we) last saw the deceased alive on 4/28 1962 and that death occurred at 1 P.M. from the causes and on the date stated above.					
22a. SIGNATURE William A Pillsbury M.D.			22b. DATE SIGNED 5-4-62		
22c. PHYSICIAN'S NAME (Type) WILLIAM A PILLSBURY			22d. ADDRESS 2060 YORK RD TIMONIAN MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Removal/Burial		MAY 5, 1962		DAVIES FUNERAL HOME	
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)	
MINNEAPOLIS, MINN.					
24. FUNERAL DIRECTOR'S SIGNATURE John Burns, Jr., Towson, Md.			25a. REC'D BY REGISTRAR DATE MAY 8 '62		
25b. REGISTRAR'S SIGNATURE Arthur L. Kline					

15260

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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville												c. LENGTH OF STAY IN lb											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3002 Woodside Avenue #34												d. STREET ADDRESS 3002 Woodside Avenue #34											
3. NAME OF DECEASED (Type or print) W. Arthur Phillips												4. DATE OF DEATH May 25, 1962											
5. SEX Male												6. COLOR OR RACE White											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH July 12, 1901											
9. AGE (In years last birthday) 60 yrs.												10. IF UNDER 1 YEAR Months Days											
11. IF UNDER 24 HRS. Hours Min.												12. CITIZEN OF WHAT COUNTRY? USA											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Work												10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. West Virginia											
11. BIRTHPLACE (State or foreign country)												12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME W. Arthur Phillips, Sr.												14. MOTHER'S MAIDEN NAME Hallie ?											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No												16. SOCIAL SECURITY NO.											
17. INFORMANT Mrs. F. Audrey Phillips- 3002 Woodside Avenue #34												Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Leenshet Wound of Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH Sudden											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) Charles F. O'Donnell												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
Address (Street, city, town, or county)												DATE SIGNED 5/25/62											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 5-28-62											
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery												22d. LOCATION (City, town, or country) (State) Pikesville, Maryland											
23. FUNERAL DIRECTOR Wm J. Jenkins & Sons Balto 17 Md.												ADDRESS											
24a. REC'D BY REGISTRAR MAY 29 '62												24b. REGISTRAR'S SIGNATURE Arthur S. Kline											

100-230

CERTIFICATE OF DEATH

Reg. Dist. No.

05532

05526

1. PLACE OF DEATH a. COUNTY BALTIMORE, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. 27 THORNHILL RD., LUTHERVILLE, MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE, MD.	c. LENGTH OF STAY IN 1b 4 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LUTHERVILLE, MARYLAND.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 THORNHILL RD., LUTH., MD.		d. STREET ADDRESS 27 THORNHILL RD., LUTH., MD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLARENCE Middle EDWARD Last PUSEY, SR.		4. DATE OF DEATH Month MAY Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1893
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY CANNING	11. BIRTHPLACE (State or foreign country) HAVRE DE GRACE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME CLARENCE CRANE PUSEY	
14. MOTHER'S MAIDEN NAME MATTIE PARKER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 074-07-1487		17. INFORMANT Address 27 THORNHILL RD., LUTH., MD. MRS. MARGARET PUSEY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO UREMIA. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE. (c)			INTERVAL BETWEEN ONSET AND DEATH 18 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. NONE 39 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE	20f. (City or town) (County) (State) NONE
21. I certify that I attended the deceased from 3 YEARS AGO , to 5-26 , 1962, that I last saw the deceased alive on 5-26 , 1962, and that death occurred at 9:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) JOPPA & OLD HARFORD RDS., BALTO. 34, MD. DATE SIGNED ACTUAL SIGNATURE Robert Sebastian PHYSICIAN'S NAME (Type) PUREN S. SEBASTIAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 29, 1962	22c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY	22d. LOCATION (City, town, or county) (State) TIMONIUM: MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WM COOK - TOWSON, INC		24a. REG'D BY REGISTRAR DATE MAY 29 1962	24b. REGISTRAR'S SIGNATURE Arthur L. Hays

1933

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

WILLIAM BOYD

NAME OF DECEASED		WILLIAM BOYD	
AGE		34	
SEX		MALE	
RACE		WHITE	
DATE OF DEATH		JANUARY 1, 1933	
PLACE OF DEATH		NEW YORK CITY	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF DECEASED			
SIGNATURE OF WITNESSES			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF CORONER			
SIGNATURE OF REGISTRAR			
SIGNATURE OF CLERK			
SIGNATURE OF JURY			
SIGNATURE OF JUDGE			
SIGNATURE OF SHERIFF			
SIGNATURE OF DISTRICT ATTORNEY			
SIGNATURE OF COUNTY CLERK			
SIGNATURE OF CITY CLERK			
SIGNATURE OF VICE MAYOR			
SIGNATURE OF MAYOR			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05527 Item 1c Film 0313 5/28/62 mb											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cathonsville						c. LENGTH OF STAY IN ID 5 yrs. 5Mths.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital						d. STREET ADDRESS Box 327 - Old North Point Rd.					
3. NAME OF DECEASED (Type or print) First Middle Last ROSIE KATHERINE RAUH						4. DATE OF DEATH Month Day Year May 20, 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1883		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Dornick						14. MOTHER'S MAIDEN NAME Rosalie Mikulec					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown						16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records; Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bilateral bronchopneumonia complicating arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) 422.1 (c), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 5/21/62			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1962		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or country) (State) Baltimore County, Maryland					
23. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.						24a. REC'D BY REGISTRAR MAY 22 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

05537

05537

(M)

(J)

Box 127 - 1st North Street
Spring Grove State Hospital

Box 127 - 1st North Street
Spring Grove State Hospital

Box 127 - 1st North Street
Spring Grove State Hospital

Box 127 - 1st North Street
Spring Grove State Hospital

Box 127 - 1st North Street
Spring Grove State Hospital

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus) c. LENGTH OF STAY IN 1b Baltimore (Arbutus) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1314 Maple Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus) d. STREET ADDRESS XXXXXX 5534 Carville Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mammie Middle Marie Last Reese		4. DATE OF DEATH Month May Day 29 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME Thomas Mills		14. MOTHER'S MAIDEN NAME Ida Brooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harry N. Reese, Sr., 5534 Carville Avenue #27		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Over the top - Hypertension DUE TO Coronary arterio sclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension - Coma DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 days 7 days 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Baltimore
21. I certify that (I) (this hospital) attended the deceased from June 14, 1962 to June 27, 1962 that (I) (we) last saw the deceased alive on June 27, 1962 and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frederic V. Beitler M.D.		22b. DATE SIGNED May 31 '62	
22c. PHYSICIAN'S NAME (Type) Frederic V. Beitler, M. D.		22d. ADDRESS 1014 Francis Avenue, Halethorpe 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/31/62	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR DATE MAY 31 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05535 CERTIFICATE OF DEATH 05529

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY in 1b <u>4 months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ba/to.</u>		3 <u>3</u> 0 <u>0</u> 1 <u>4</u>	
3. NAME OF DECEASED (Type or print) <u>Bent Nursing Home</u> First Middle Last				4. DATE OF DEATH <u>May 16, 1962</u> Month Day Year		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1890</u>	9. AGE (in years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Jamaica L.I.N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Soaris</u>		14. MOTHER'S MAIDEN NAME <u>ANN ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wesley Reid</u>		Address <u>117 N. Carlton St.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Vascular Accident</u> (c) <u>Arteriosclerosis - generalized</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 16, 1962</u> to <u>May 15, 1962</u> , that (I) (we) last saw the deceased alive on <u>May 15, 1962</u> , and that death occurred at <u>12:15 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles E. Williams</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 16, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Reisterstown</u>				22d. ADDRESS <u>Maryland</u>			
23a. BURIAL, CREMATION, EMBOWAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cem.</u>		23d. LOCATION (City, town or country) (State) <u>Croft Hill Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Harry R. Williams</u>				ADDRESS <u>322 N. School St.</u>		25a. REC'D BY REGISTRAR <u>May 21 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Williams</u>			



3261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

05536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05530

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM		c. LENGTH OF STAY IN 1b X TIMONIUM	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2100 EASTHAM ROAD		d. STREET ADDRESS 2105 EASTHAM RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle THERESE Last RENNEX		4. DATE OF DEATH Month MAY Day 2 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 18, 1893
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - GIFT SHOP		10b. KIND OF BUSINESS OR INDUSTRY OWNER - RETAIL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES DOBIN		14. MOTHER'S MAIDEN NAME JESSIE HALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 216-12-917A	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease with Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthmatic Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from Jan. 1964 to July 1962 that (I) (not) last saw the deceased alive on 29 April 1962 , and that death occurred at 7:45 AM, from the causes and on the date stated above.			
22a. SIGNATURE Wm. H. Kammer, Jr.		22b. DATE SIGNED 1962	
22c. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr.		22d. ADDRESS 6011 York Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 5, 1962	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		23d. LOCATION (City, town, or county) (State) PIKESVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons, Towson, Md.		25a. REC'D BY REGISTRAR MAY 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

3623

(M)

CHIEF JAMES

RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05537
05531
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St Joseph Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE XXXXXX Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe d. STREET ADDRESS 4506 Linden Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EULA V. RHODES First Middle Last		4. DATE OF DEATH MAY 26, 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown WARREN	
14. MOTHER'S MAIDEN NAME PAMALA PRINCE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Warren Arnold, 17 E. Saratoga St Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) General arterio sclerosis DUE TO (c) Respiratory system terminal		INTERVAL BETWEEN ONSET AND DEATH 20 yrs 19 w 48	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 26, 1962 , to May 26, 1962 , that (I) (we) last saw the deceased alive on May 26, 1962 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Frederic V. Butler M.D.		22b. DATE SIGNED MAY 29 '62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1014 Francis Ave - Balto 27-Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR MAY 29 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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MAY 22, 1961

MAY 22, 1961

JANUARY 1961

JANUARY 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05538

CERTIFICATE OF DEATH

05532

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 29yr9mth20dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3001-4 d. STREET ADDRESS 2708 Gibbons Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle A. Last Rial		4. DATE OF DEATH Month May Day 23 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1887
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HRS. Hours 8 Mln. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone operator		10b. KIND OF BUSINESS OR INDUSTRY C & P.	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Joseph P. Rial	
14. MOTHER'S MAIDEN NAME Mary E. (Kriener) Kreiner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records : SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myeloid leukemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 8:00 e.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 3, 1932 to May 23, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 23, 1962 , and that death occurred at 8:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D.		22b. DATE SIGNED 5-23-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/26/62	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck Inc		25a. REC'D BY REGISTRAR MAY 25 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 5305 HARFORD Rd.	

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cockeysville</u>		c. LENGTH OF STAY in lb <u>13 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>				d. STREET ADDRESS <u>300 Westwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Estelle M Rice</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 22, 1880</u>			
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co., Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>									
13. FATHER'S NAME <u>Thomas C. Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Annie Barlow</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Masonic Home Records - Cockeysville Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerotic Caudex - was arterial disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>gro.</u>	
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>Oct</u> 19 <u>61</u> to <u>May</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>May 1</u> 19 <u>62</u> , and that death occurred at <u>5:35 P.</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Elizabeth B. Sherrill</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/1/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill MD</u>				22d. ADDRESS <u>Cockeysville Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>				25a. REC'D BY REGISTRAR <u>MAY 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MEDICAL CERTIFICATION

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504-505

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 3 mos. 28da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Janet Middle Irene Last RICKARD		4. DATE OF DEATH Month 5 Day 1 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/47
9. AGE (In years, last birthday) yrs. 14		10. IF UNDER 1 YEAR: Months 14 Days 1 Hours 19 Min. 62	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		11b. KIND OF BUSINESS OR INDUSTRY none	
12. BIRTHPLACE (State or foreign country) Washington, D.C.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME George Rickard		15. MOTHER'S MAIDEN NAME Grace Louise Greenwood	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		17. SOCIAL SECURITY NO. none	
18. INFORMANT Rosewood Records, Owings Mills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral broncho-pneumonia 352 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) complicating spastic quadriplegia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) slow degenerative process (Pelizaeus Merzbacher disease)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) (1 yr)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) we (County) (State)	
21. I certify that he attended the deceased from 1/4 , 19 62 , to 5/1 , 19 62 , that he last saw the deceased alive on 5/1 , 19 62 , and that death occurred at 10:01a M, from the causes and on the date stated above			
ACTUAL SIGNATURE Harry G. Butler M.D.		ADDRESS (Street, city or town, state) Owings Mills, Md DATE SIGNED 2/5/62	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/62	
22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE MAY 4 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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CERTIFICATE OF DEATH

Relief Committee
Copies of the
Certificate of Death

George Washington

1910

1910

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Harrisonburg Expressway c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 530 E. 20th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Charlie Middle CHARLES Last RICKS, JR.					4. DATE OF DEATH Month May Day 19 Year 1962				
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1918		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Manuf.		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Charlie Ricks					14. MOTHER'S MAIDEN NAME Louise Whitaker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 238-18-6096		17. INFORMANT Orbie Ricks Address 530 E. 20th St. Balt., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Multiple traumatic injuries to head and neck and trunk 819X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) and trunk (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. yes					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile that hit Seminary Avenue Bridge abutment on Harrisonburg Expressway				
20c. TIME OF INJURY Month, Day, Year 7 5/19 19 62					20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway				
20e. (City or town) Baltimore Co. Md.					20f. (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. Breiteneker M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R. Breiteneker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 19, 1962 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-22-62		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or country) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR Charles B. Lewis ADDRESS 1639 N. Broadway					24a. REC'D BY REGISTRAR DATE MAY 22 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

FOR STATE
HEALTH DEPT



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MASSACHUSETTS DEPARTMENT OF HEALTH
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STATE DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05542 CERTIFICATE OF DEATH 05536

1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		d. STREET ADDRESS 113 Marykay Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 Marykay Road									
3. NAME OF DECEASED (Type or print) HENRY		First CHRISTIAN		Middle RIX		Last May 30, 1962		4. DATE OF DEATH Month Day Year 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1894		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paymaster		10b. KIND OF BUSINESS OR INDUSTRY Commercial Credit		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Christian Rix				14. MOTHER'S MAIDEN NAME Anna Link					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Navy-WW1		17. INFORMANT Mildred Rix Preston-113 Marykay Rd.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Parkinsons Disease 350X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs								INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (1) (this hospital) attended the deceased from July , 19 59 , to May 30, 1962 , that (1) (we) last saw the deceased alive on May 1, 1962 , and that death occurred at 3 P.M. , from the causes and on the date stated above.									
22c. SIGNATURE George T. Gilmore M.D.				22d. ADDRESS Lanham Building Lutherville, Md.		22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2/62		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. York Rd., Towson, Md.				ADDRESS		25a. REC'D BY REGISTRAR 4 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

(M)

Baltimore

Interville

113 Parkway Road

HEAVY

White

Refined Paymaster

Christian Six

Yes Navy-W-1

CHRISTIAN

NIX

May 30, 1962

Oct. 3, 1964

Commercial Credit - Baltimore, Maryland U.S.

Anna Link

512-01-7014 - Milled Six Preston-113 Parkway Rd.

Bureau

June 2/62 Parkwood

Baltimore, Maryland

Wm Cook-Townson, Inc. York Rd., Towson, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05543
CERTIFICATE OF DEATH
05537

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. 11-13-59 5 13-62 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 30. d. STREET ADDRESS 2117 Parkley Ave. 1005 Sterret Street, Balto 30 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Joseph Robbins		4. DATE OF DEATH Month May Day 13 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1925 1914
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 13	11. IF UNDER 24 HRS. Hours 13 Min. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Robbins		14. MOTHER'S MAIDEN NAME Louise Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-1621	
17. INFORMANT Hospital record. Spring Grove State Hospital		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 150 X DUE TO Hemoptysis.- Postoperative complication of Carci- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO noma of the esophagus. INTERVAL BETWEEN ONSET AND DEATH Undetermined		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Nov. 13, 1959 to May 13, 1962 that (I) (we) last saw the deceased alive on May 13, 1962 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE WERTHIDE J. FLEISCHMANN M.D.		22b. DATE SIGNED 5/13/1962	
22c. PHYSICIAN'S NAME (Type) WERTHIDE J. FLEISCHMANN		22d. ADDRESS Spring Grove ST. 4, Catonsville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-16-62	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem	23d. LOCATION (City, town or county) (State) Glen Burnie Md.
24. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan & Son Inc - Balto 23,		25a. REC'D BY REGISTRAR MAY 16 1962	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05544 CERTIFICATE OF DEATH 05538

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Baltimore MARYLAND Rural - Pikesville, Md. 17 days Mt. Wilson State Hospital		MARYLAND BALTIMORE COUNTY X SPARROWS POINT 12628 MARINE AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last HILDA LEE RODVAN		4. DATE OF DEATH Month Day Year MAY 5 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/16/28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT - BAR	9. AGE (In years last birthday) 33 yrs.
11. BIRTHPLACE (County & State, or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC VICAIRE		14. MOTHER'S MAIDEN NAME MARY SAPPHER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 204-26-6787		16. INFORMANT Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 18, 1962 to MAY 5, 1962 that (I) (we) last saw the deceased alive on MAY 5, 1962 and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 5/5/62	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-8-1962	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn
23d. LOCATION (City, town or county) Eastern Ave. Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22. Md.		25a. REC'D BY REGISTRAR DATE MAY 7 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "May 18" and "May 2" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05545 CERTIFICATE OF DEATH 05539

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN It Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6159 Northdale Road		d. STREET ADDRESS 6159 Northdale Road	
3. NAME OF DECEASED (Type or print) Ellen I. Rogers		4. DATE OF DEATH May 31 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Armstrong Dixon		14. MOTHER'S MAIDEN NAME Mary Amelia Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Joseph C. Overstreet		Address 6159 Northdale Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASTHMA - CARDIOVASCULAR DISEASE 422.1 DUE TO CHRONIC - Conditions, if any, which gave rise to immediate cause (b) DIAPHRAGM - CERVICAL (c) APPROXIMATELY 100% CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 5/1 1961 to 5/31 1962 that (I) (we) last saw the deceased alive on 5/31 1962 and that death occurred 9.25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John H. Shaw M.D.		22b. DATE SIGNED 6/1/62	
22c. PHYSICIAN'S NAME (Type) John H. Shaw M.D.		22d. ADDRESS 5500 EMMINGHAM AVE. ROCK SPRING	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 1962	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Norace F. Burgee		25a. REC'D BY REGISTRAR JUN 4 '62	
ADDRESS 3631 Falls Road Baltimore		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not taken to the hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05546

05540

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River c. LENGTH OF STAY IN 1b Middle River d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1616 Wilson Point Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River d. STREET ADDRESS 1616 Wilson Point Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDMUND F. ROSENBERGER		4. DATE OF DEATH May 22, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1891
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 5 Days 22 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY General Store	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Rosenberger	
14. MOTHER'S MAIDEN NAME Rebecca Eberline		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Laura Rosenberger Address 1616 Wilson Point Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure Conditions, if any, which gave rise to immediate cause (b) Heart attack (coronary obstruction) (a), stating the underlying cause last. (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Diabetes mellitus ② Cerebral hemorrhage 9 yrs ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 5/22 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel, Md.		20f. (City or town) 5/22 (County) 62 (State) 62	
21. I certify that (I) (this hospital) attended the deceased from Laurel, Md. 5/22 to 5/22 , 19 62 ; that (I) (we) last saw the deceased alive on 5/22 , 19 62 , and that death occurred at 9:10 PM , from the causes and on the date stated above.			
22. SIGNATURE Eugene C. Baumann M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/24/62	
22c. PHYSICIAN'S NAME (Type) E.C. Baumann, M.D.		22d. ADDRESS 413 Eastern Avenue, Essex Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1962	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town or county) Parkville, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR MAY 31 62 DATE 62	
25b. REGISTRAR'S SIGNATURE Wm. S. Thayer			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05547

05541

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>—</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>6 1/2 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Mad. Masonic Homes</i>			d. STREET ADDRESS <i>1623 E. North Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Nathalie</i> Middle <i>Wilson</i> Last <i>Rutledge</i>			4. DATE OF DEATH Month <i>May</i> Day <i>11</i> Year <i>1962</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 27, 1882</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore City, Md.</i>	
13. FATHER'S NAME <i>Warren Paynter</i>			14. MOTHER'S MAIDEN NAME <i>Alice Wilson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Masonic Home Records - Cockeysville Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes Mellitus</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>—</i> DUE TO (c) <i>—</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic cardiovascular disease</i>					INTERVAL BETWEEN ONSET AND DEATH <i>16 yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1961</i> to <i>May 1962</i> , that (I) (we) last saw the deceased alive on <i>May 11, 1962</i> , and that death occurred at <i>10:21 A.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Elizabeth B. Sherwill</i>			22b. DATE <i>5/11/62</i>		22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherwill</i>
22d. ADDRESS <i>Cockeysville Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5-14-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	
23d. LOCATION (City, town or county) <i>Baltimore</i>		23e. REC'D BY REGISTRAR <i>MAY 14 '62</i>		23f. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</i>					

VR A15 (4)
15M 9/60

5400

W. C. C. Co., Inc., 1117 St. Paul Street, Baltimore 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05548

05542

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SHERWOOD ROAD				d. STREET ADDRESS SHERWOOD RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE LOUISE SACRA				4. DATE OF DEATH MAY 9, 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 1, 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES S. PROSSER				14. MOTHER'S MAIDEN NAME EMMA JANE ADER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address FAMILY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 420.0 DUE TO Gen. Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Gen. Rheumatoid Arthritis (b) Gen. Arteriosclerosis (c) Gen. Rheumatoid Arthritis						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. ? 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 54 to 5-9- , 19 62 that (I) (we) last saw the deceased alive on 5-9- , 19 62 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert H. Silver				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-12-62	
22c. PHYSICIAN'S NAME (Type) R. H. Silver				22d. ADDRESS 3105 N. Charles St. Balto. 18, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 12, 1962		23c. NAME OF CEMETERY OR CREMATORY JESSOP'S CEMETERY		23d. LOCATION (City, town or county) (State) COCKEYSVILLE, MD	
24. FUNERAL DIRECTOR'S SIGNATURE John Burnie Sone, Towson, Md				25a. REC'D BY REGISTRAR MAY 15 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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ROCKFORD
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STERN ROAD

MINNIE

FRANK WHITE

HOUSEWIFE

CHARLES ST. PROSSER

Mr

MARYLAND

COCKEYVILLE

CHERRY ROAD

LOUISE

Nov 11 1892

MARYLAND

EMMA JANE ROSS

EMMA RECORDS

Antisiphonite Heart Disease

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the Antisiphonite

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P. H. H. H.
P. H. H. H.

John Brown's ...
May 11, 1892 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05549													
05544													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit WURN. Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>N. Linticum</u> d. STREET ADDRESS <u>40 Badgers Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Matta</u> Middle <u>A.</u> Last <u>Severloff</u>						4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1962</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>02</u> Days <u>X</u> Hours <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Isaac Marsh</u>						14. MOTHER'S MAIDEN NAME <u>Mary</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		Address <u>same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Amputation old mid thigh</u> (c) <u>Right</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Obliterans</u>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>14 May 62</u> to <u>30 May 62</u> , that (I) (we) last saw the deceased alive on <u>5/29/62</u> , and that death occurred <u>7:40 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>W.E. McGrath</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/30/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath</u>						22d. ADDRESS <u>1303 Frederick Rd Catonsville Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>6-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cem.</u>		23d. LOCATION (City, town or county) <u>Georgetown, Del.</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCurly Funeral Home 130 E. Fort Ave.</u>						25a. REC'D BY REGISTRAR <u>JUN 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7733 Baltimore Ave.</u>					d. STREET ADDRESS <u>7733 Baltimore Ave.</u>						
3. NAME OF DECEASED (Type or print) First <u>Dice</u> Middle <u>Pearl</u> Last <u>See</u>					4. DATE OF DEATH Month <u>5</u> Day <u>-17-</u> Year <u>19 62</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-1911</u>		9. AGE (in years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>19</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eastern Stainless Steel Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert L. See</u>					14. MOTHER'S MAIDEN NAME <u>Clara Buckalow</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>30262151</u>				16. SOCIAL SECURITY NO. <u>30262151</u>		17. INFORMANT <u>Daisy See</u>		Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>M.B. Davis</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>5/17/62</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) <u>Cheshire, Ohio</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5-21-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cheshire Cemetery</u>			22d. LOCATION (City, town, or county) <u>Cheshire, Ohio</u>			(State)	
23. FUNERAL DIRECTOR <u>L. J. Ruck Inc. 5305 Harford Road</u>					ADDRESS <u>L. J. Ruck Inc. 5305 Harford Road</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		

00555

00555

(M)



(1)

W



1011 Park Heights, Balto. Md.
Cathedral Cemetery, Balto. Md.
6/1/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05553

CERTIFICATE OF DEATH

05548

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Nr. Baltimore City c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2308 Putty Hill Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nr. Baltimore City d. STREET ADDRESS 2308 Putty Hill Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES FRANKLIN SETTLEMOIR		4. DATE OF DEATH Month May Day 16 Year 19 62				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1868	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 93 Days 93	IF UNDER 24 HRS. Hours 93 Min. 93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miscell.		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William M. Settlemoir		14. MOTHER'S MAIDEN NAME Elizabeth Phelam				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mrs. Alberta Berk 2308 Putty Hill Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 600.0 IMMEDIATE CAUSE (a) Chronic Peptonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 1958 to May 16, 1962 that (I) (we) last saw the deceased alive on May 14, 1962 and that death occurred at 6 P.M. from the causes and on the date stated above.						
22a. SIGNATURE George Sawyer M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4808 Harford Rd. Balto Md.		22b. DATE SIGNED 5/18/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.		ADDRESS 715 Light St. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE MAY 21 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna

M

1

Baltimore

Mr. Baltimore City

2008 North Hill Ave.

JAMES KENNEDY BIRMINGHAM

Oct. 28, 1968

Illinois

Baltimore

Baltimore

William . Baltimore

Mrs. Baltimore

Mrs. Baltimore 2008 North Hill Ave.

Baltimore, Md.

5/2/68

1111 1111

05554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		1601-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>				d. STREET ADDRESS <u>1009 Harrison St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Shelton</u> Last <u>Shelton</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>MARCH 27 1906</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mutual Teller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Truck</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL Shelton</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edith Shelton</u> Address <u>1009 Harrison St. Laurel MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yr.</u> <u>10 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 6</u> , 19 <u>1906</u> to <u>May 17</u> , 19 <u>1962</u> ; that I last saw the deceased alive on <u>May 13</u> , 19 <u>1962</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert S. McGeney</u> M.D.				ROBERT S. MCGENEY M.D. 402 MAIN ST. LAUREL, MD.			
PHYSICIAN'S NAME (Type)				DATE SIGNED <u>5/17/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/17/62</u>		<u>Fort Lincoln</u>		<u>Catonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sterling Butler</u>				ADDRESS <u>Lee Funeral Home</u> <u>300 - 4th St. NE.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 16 '62</u>	
						24b. REGISTRAR'S SIGNATURE <u>Clifton S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1914

M

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1869</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>City of Baltimore</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>9. TIME OF DEATH</p> <p><i>10:30 AM</i></p>		<p>10. DATE OF DEATH</p> <p><i>Dec 10 1914</i></p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>12. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>14. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05551

05546

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LUTHERVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MAYS' CHAPEL ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LUTHERVILLE d. STREET ADDRESS MAYS' CHAPEL ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OLIVER MAULDIN SHOCK				4. DATE OF DEATH MAY 25, 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 23, 1893	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED			
13. FATHER'S NAME SHOCK				14. MOTHER'S MAIDEN NAME ROSE Winemaster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI				16. SOCIAL SECURITY NO. 218-01-1269			
17. INFORMANT FAMILY RECORDS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) } (c) DUE TO } (e), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 22. INTERVAL BETWEEN ONSET AND DEATH 5 Days 23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 29, 1962		22c. NAME OF CEMETERY OR CREMATORY SATERS' CEMETERY		22d. LOCATION (City, town, or country) (State) LUTHERVILLE, MD	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.				24. REC'D BY REGISTRAR JUN 1 '62			
				24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

MEDICAL CERTIFICATION

DATE SIGNED **5/25/62**

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05555

05550

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ste 11a Maris Hospice</u>		d. STREET ADDRESS <u>3115 Rosalie Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>First Mable Shugars</u> Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/1894</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Shugars</u>		14. MOTHER'S MAIDEN NAME <u>Julia Yingling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-34-2202</u>	
17. INFORMANT <u>Admission Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Respiratory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>ASCD.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>60</u> , to <u>May 1</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>62</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>602 E. Joppa Rd. Towson 4, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Robert J. Mahon</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/6/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Ruck Inc</u>		ADDRESS <u>5305 HARFORD Rd.</u>	
24a. REC'D BY REGISTRAR <u>MAY 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1955

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MD. b. COUNTY BALTO. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5228 CROMARTY RD.				e. STREET ADDRESS 5228		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARETHA MARGARET Middle Last SIEGMAN				4. DATE OF DEATH MAY 9 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1880	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ? ADDAMONT			14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address CLARA WALDVOGEL 5228 CROMARTY RD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semibility							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1, 1962 to May 9, 1962 , that I last saw the deceased alive on May 8, 1962 , and that death occurred at 4:29 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. MacLaughlin				ADDRESS (Street, city or town, state) 4508 Edmondson Village		DATE SIGNED 5/10/62	
PHYSICIAN'S NAME (Type) D. MacLaughlin							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-12-1962		22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY		22d. LOCATION (City, town, or county) (State) 5608 DOGWOOD RD. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Weber				ADDRESS 5311 EDMONDSON AVE		24a. REC'D BY REGISTRAR MAY 10 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of identifying a problem is to recognize that a problem exists. This is often done by comparing current performance with a desired state or goal. If there is a significant difference, a problem is identified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05557

05552

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 108 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 1621 Latrobe Street i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM I. SIMPKINS			4. DATE OF DEATH MAY 18 1962		
5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 5, 1893 9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk 10b. KIND OF BUSINESS OR INDUSTRY Dime Store 11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Simpkins 14. MOTHER'S MAIDEN NAME Mary Hawkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I 16. SOCIAL SECURITY NO. 217-01-4332 17. INFORMANT Clinical Records, VA Hospital Address Fort Howard, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. OBSTRUCTIVE EMPHYSEMA (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) RHEUMATOID ARTHRITIS 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour 19 Month, Day, Year 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) May Jan. 30, 1962 (County) May 18, 1962 (State) 1962		
21. I certify that (X) (this hospital) attended the deceased from May Jan. 30, 1962 to May 18, 1962 that (X) (we) saw the deceased alive on May 18, 1962 and that death occurred at 2:00 P.M. from the causes and on the date stated above.			22a. SIGNATURE Sebastian Russo 22b. DATE SIGNED 5/18/62 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D. 22d. ADDRESS VAH. FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-22-62 23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem Baltimore Md 23d. LOCATION (City, town or county) Baltimore Md (State) Md			24. FUNERAL DIRECTOR'S SIGNATURE Chay O. Wilson 25a. REC'D BY REGISTRAR MAY 24 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05553										
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN lb 1 Mo. 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS Md. Hotel, Baltimore St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT SIMPSON					4. DATE OF DEATH Month Day Year 5 4 1962					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-26-1895		9. AGE (In years or birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME CHARLES S. SIMPSON					14. MOTHER'S MAIDEN NAME IDA CLARK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES N.W.I.					16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PULMONARY Tuberculosis Carcinoma of the Lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-21-1962 to 5-4-1962 that (I) (we) last saw the deceased alive on 5-4-1962, and that death occurred at 9:15 AM from the causes and on the date stated above.										
22a. SIGNATURE W. Newcomer					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/4/62		
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent					22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.					
23a. BURIAL, CREMATION, or REMOVAL (Specify)			23b. DATE THEREOF May 8 62		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION (City, town or county) (State) Baltimore Md			
24. FUNERAL DIRECTOR'S SIGNATURE P. A. Deewan					ADDRESS 6067 Hayford Rd		25a. REC'D BY REGISTRAR MAY 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1333

(M)

3.3.1

(J)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

FOR STATE
HEALTH DEPT.

MAY 13 1962											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05559											
05554											
1. PLACE OF DEATH											
a. COUNTY <u>Baltimore</u> MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)											
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>											
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
X <u>DUNOALK</u>											
d. STREET ADDRESS											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)											
First Middle Last											
<u>ETTA LEE SKILES</u>											
4. DATE OF DEATH											
Month Day Year											
<u>MAY 12 1962</u>											
5. SEX											
F											
6. COLOR OR RACE											
W											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>											
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH											
6-3-13											
9. AGE (In years last birthday)											
48 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)											
10b. KIND OF BUSINESS OR INDUSTRY											
11. BIRTHPLACE (State or foreign country)											
W. VIRGINIA											
12. CITIZEN OF WHAT COUNTRY?											
USA											
13. FATHER'S NAME											
DUDE HURT											
14. MOTHER'S MAIDEN NAME											
MINERVA THOMPSON											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)											
16. SOCIAL SECURITY NO.											
23-5-28-0607											
17. INFORMANT Address											
SYLVIA SKILES 2116 Willow Sp. Rd.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>											
422.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
(e), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
Acute barbiturate intoxication											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
By an overdose of barbiturates											
20c. TIME OF INJURY Month, Day, Year											
Hour <u>1:00</u> p.m. <u>May 12, 62</u>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
Home											
20f. (City or town) (County) (State)											
Baltimore Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
DATE SIGNED											
MAY 13, 1962											
22a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
22b. DATE THEREOF											
5-16-62											
22c. NAME OF CEMETERY OR CREMATORY											
OAK LAWN											
22d. LOCATION (City, town, or country) (State)											
COLGATE, MA.											
23. FUNERAL DIRECTOR ADDRESS											
ULLRICH FUN. HOME. BALTO. CO., MD.											
24a. REC'D BY REGISTRAR											
MAY 21 '62											
24b. REGISTRAR'S SIGNATURE											
Arthur L. Frank											

(M)

(E)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05560 CERTIFICATE OF DEATH 05555

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore g. STREET ADDRESS 1535 Light Street h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle W. Last Slater		4. DATE OF DEATH Month May Day 1 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 3, 1897
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Slater		14. MOTHER'S MAIDEN NAME Mary Connelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 214-12-9241	
17. INFORMANT Clinical Records, Veterans Administration Hospital, Fort Howard, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) METASTASIS TO LIVER (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28 , 19 62 , to May 1 , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 1 , 19 62 , and that death occurred at 2:55AM from the causes and on the date stated above.			
22a. SIGNATURE Sebastian Russo		22b. DATE SIGNED 5/1/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/5/62	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City, town or county) (State) BALTIMORE MD
24. FUNERAL DIRECTOR'S SIGNATURE L J Ruck Inc		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

45555

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James Hill

VAL. 1918, 1919, 1920

RECEIVED 1920, 1921, 1922

General Office for the State of New York

State of New York, Albany

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
05561																			
05556																			
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Smallwood</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home Balto 28</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>13 Holmehurst Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>JENNIE</u>					4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1962</u>														
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29, 1869</u>		9. AGE (In years last birthday) <u>92</u> yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>												
13. FATHER'S NAME <u>Phillip Croncy</u>					14. MOTHER'S MAIDEN NAME <u>?</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>SON, EARL K. Smallwood - 13 Holmehurst</u> Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.2</u> DUE TO <u>Carcinoma of the Descending Colon</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Oct 61 May 9 62</u>		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 61</u> to <u>May 9 62</u> , that (I) (we) last saw the deceased alive on <u>8 May 1962</u> and that death occurred <u>9:30 AM</u> , from the causes and on the date stated above.										22a. SIGNATURE <u>W. E. Mc Grath</u> M.D.					22b. DATE SIGNED <u>5/9/62</u>				
22c. PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath</u>					22d. ADDRESS <u>1303 Frederick Rd</u>					(State) <u>MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 13 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>			23d. LOCATION (City, town or county) <u>Harvard Co.</u>			(State) <u>MD</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. B. Mac Nabbs</u> ADDRESS <u>Balto 28 Md</u> <u>301 Frederick Ave.</u>					25a. REC'D BY REGISTRAR <u>MAY 14 '62</u>					25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									



05551

Ballroom

05556

Ballroom

M2

Summit Nursing Home, 12 Holmes St., New York

Donnie Williams

W. T. Williams

Housewife

Philip Cheney

do

204, East 12th St., New York

William T. Williams

Philip Cheney

W. T. Williams

Summit Nursing Home, 12 Holmes St., New York

Philip Cheney

12 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05562

05557

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>		c. LENGTH OF STAY IN It <u>21 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>		d. STREET ADDRESS <u>1945 Walnut Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1945 Walnut Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER JOHN SMITH</u>				4. DATE OF DEATH Month Day Year <u>May 21st 1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1913</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tide Water Fisheries / Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Smith, Sr.,</u>				14. MOTHER'S MAIDEN NAME <u>Anna Schultzski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-01-4696</u>		17. INFORMANT Address <u>Mrs. Norma S. Munski, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M B Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/22/62</u>	
EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Dundalk 22, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Walter Brooks Bradley, Inc., Dundalk 22, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 24 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

03234

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05563 CERTIFICATE OF DEATH 05558

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3017 Woodside Ave.</u>				d. STREET ADDRESS <u>3017 Woodside Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie E. (Christian) Smoot</u>				4. DATE OF DEATH Month Day Year <u>May 27 19 62</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-26-1869</u>	
9. AGE (in years last birthday) <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balto. Towel Supply Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Smoot</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Walsh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>215031706</u>		17. INFORMANT <u>Mrs Charles F. Zeller</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, Cerebral, Massive, Left.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis, Generalized, Massive</u> (c) <u>± 20 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>16 May 1962</u> to <u>27 May 1962</u> , that (I) (we) last saw the deceased alive on <u>26 May 1962</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward L. Molz</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>28 May 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward L. J. Molz, M.D.</u>				22d. ADDRESS <u>7425 Harford Rd Balto. 34 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5-30-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc. 5305 Harford Road</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 31 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Garden Ridge Road #28		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Harry Snyder		4. DATE OF DEATH Month Day Year May 5, 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1880
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Snyder		14. MOTHER'S MAIDEN NAME Ophelia Egger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Esther P. Snyder- 201 Garden Ridge Rd. #28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Hypertensive Cardio Vascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 days one year 7/24/62
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured right hip 3/23/62			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/26 , 19 57 , to 5/5 , 19 62 that I last saw the deceased alive on 5/4 , 19 62 , and that death occurred at 11:15 A from the causes and on the date stated above.			
ACTUAL SIGNATURE Eliot W. Johnson M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 5/7/62	
PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-8-62	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Johnson		ADDRESS Balt 17, Md.	
24c. REC'D BY REGISTRAR DATE MAY 8 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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05560

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Halethorpe) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2029 Monumental Avenue		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Halethorpe) d. STREET ADDRESS 2029 Monumental Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert or (Bolesleus) C. Sobus, Sr.		4. DATE OF DEATH May 4, 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		10b. KIND OF BUSINESS OR INDUSTRY Walters Art Gallery Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Sobus		14. MOTHER'S MAIDEN NAME Marcianya Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Martha M. Sobus, 2029 Monumental Ave. #27		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Congestive heart failure & S.C.V.D. Coronary Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19....., to May 4, 1962 , that (I) (no) last saw the deceased alive on May 2, 1962 , and that death occurred at 9:20 M, from the causes and on the date stated above.			
22a. SIGNATURE John C. Healy M.D.		22b. DATE SIGNED 5/4/62	
22c. PHYSICIAN'S NAME (Type) John Healy, M.D.		22d. ADDRESS Francis Avenue, Halethorpe 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/62	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town or county) (State) XXXX Elkrige, Howard Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR MAY 7 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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NEW YORK, N.Y.
JANUARY 10, 1910

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

455 FIFTH AVENUE, NEW YORK, N.Y.

DEAR MR. TILDEN:

SIR,

PLEASE FIND

ENCLOSED A COPY OF THE

REPORT

OF THE COMMISSIONERS OF THE
LAND OFFICE, NEW YORK

VERY TRULY
YOURS,

W. L. G.

W. L. G.

W. L. G.

W. L. G.

W. L. G.

W. L. G.

W. L. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05561

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines (Catonsville)		d. STREET ADDRESS 717 Winans Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margie Josephine Sprecher		4. DATE OF DEATH Month May Day 31 Year 1962		5. AGE (In years last birthday) 91 yrs.	
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 11, 1870		9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 4 Days 29	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel C. Brewer	
14. MOTHER'S MAIDEN NAME Angelica Huyett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Grover Brown		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Advanced and longstanding arteriosclerotic cardiovascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the attending physician) attended the deceased from 2 Oct. 1962 to 31 May 1962 that (I) (no) last saw the deceased alive on 29 May 1962 , and that death occurred at 6 PM , from the causes and on the date stated above. 22a. SIGNATURE Emil H. Henning Jr M.D. 22b. DATE SIGNED 1 JUNE 62 22c. PHYSICIAN'S NAME (Type) EMIL H HENNING JR 22d. ADDRESS 601 WINANS WAY (29)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Church	
23d. LOCATION (City, town or county) (State) Clearspring, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR JUN 5 '62	
25b. REGISTRAR'S SIGNATURE R. H. S. Hume		25c. ADDRESS 8728 Liberty Road		25d. DATE Bendallstown, Maryland	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05567 CERTIFICATE OF DEATH 05562

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Res., 7608 Poplar Road 22, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Frances Stahler		4. DATE OF DEATH Month Day Year May 17 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1874
9. AGE (In years last birthday) 88 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Wilkerson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT William E. Stahler		Address 7608 Poplar Rd. 22, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 154X DUE TO Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 1955 , 19 55 , to May 17 , 19 62 , that (I) (we) last saw the deceased alive on May 16 , 19 62 , and that death occurred at 1 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Morris A. Jacobs M.D.		22b. DATE SIGNED May 17 1962	
22c. PHYSICIAN'S NAME (Type) Morris A. Jacobs		22d. ADDRESS 1010 North Point Rd. 22, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 20, 1962	23c. NAME OF CEMETERY OR CREMATORY Wiseburg Cem.	23d. LOCATION (City, town or county) (State) White Hall, Md.
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		25. REC'D BY REGISTRAR MAY 22 '62	
ADDRESS 7922 Wise Ave. 22, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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Page 10
Page 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05568

05563

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 3028 Arunah Avenue i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DAVID Middle A. Last STAINBACK		4. DATE OF DEATH Month MAY Day 17 Year 1962							
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1913	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 4 Days 17 Hours 17 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apparatus Attendant		10b. KIND OF BUSINESS OR INDUSTRY Telephone Company		11. BIRTHPLACE (County & State, or foreign country) Brunswick Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alfred Stainback		14. MOTHER'S MAIDEN NAME Alice Powell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 219-03-5655		17. INFORMANT Clinical Records, VA Hospital Fort Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) METASTASIS BRAIN AND CEREBELLUM DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from May 1, 1962 to May 17, 1962 , that (s) (we) last saw the deceased alive on May 17, 1962 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Sebastian Russo M.D. 22b. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, FORT HOWARD, MARYLAND		22c. DATE SIGNED 5/17/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-21-62		23c. NAME OF CEMETERY OR CREMATORY Balto Nat'l Cem		23d. LOCATION (City, town or county) (State) Balto Md			
24. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Home ADDRESS 1011-13 N. Arlington Ave				25a. REC'D BY REGISTRAR MAY 21 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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WILLIAM H. HARRIS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRANZELSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LIBERTY COURT REHABILITATION CENTER		d. STREET ADDRESS 3509 BERWYN AVE	
3. NAME OF DECEASED (Type or print) First Anna Middle STERN Last STERN		4. DATE OF DEATH Month MAY Day 14 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOT KNOWN
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S. 9	
13. FATHER'S NAME BENJAMIN		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT HARRY STERN Address SOME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL DECOMPENSATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ARTERIOSECTERIC CARDIOVASCULAR DISEASE DUE TO (c) CEREBROVASCULAR ACCIDENT - CEREBRAL ARTERIO SCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1960 to 5-13-1962 that I last saw the deceased alive on 5-13-1962 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Ackelbaum M.D.		ADDRESS (Street, city or town, state) 4017 LIBERTY HEIGHTS AVE. BALTIMORE 7, MD.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 5-13-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/14/1962	22c. NAME OF CEMETERY OR CREMATORY HERRING RUN	22d. LOCATION (City, town, or county) (State) BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Ackelbaum		24a. REC'D BY REGISTRAR DATE MAY 15 '62	
24b. REGISTRAR'S SIGNATURE William S. Thorne			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

STATE OF DEATH

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Witness

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05570

05565

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) Armacost Nursing Home, 812 Register Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Graham Stewart, Jr. Middle Last 		4. DATE OF DEATH Month 5-5- Day 19 Year 62	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-1891	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) expeditor		10b. KIND OF BUSINESS OR INDUSTRY Radio Mfg.	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. G. Stewart, Sr.		14. MOTHER'S MAIDEN NAME ?????? Barton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 366-03-2655	
17. INFORMANT Mrs. Hazel J. Stewart,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage 157X DUE TO Obstructive jaundice & hyperparathyroidism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Larcenomatosis abdominalis pancreatic (c) ?		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 mo ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 13, 1962 to May 5, 1962 that (I) (we) last saw the deceased alive on May 4, 1962 and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE Frederick J. Vollmer		22b. DATE SIGNED May 7, 62	
22c. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		22d. ADDRESS 6100 York Rd Balto-12, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-7-62	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc., Towson 4, Md.		25a. REC'D BY REGISTRAR MAY 8 '62	
25b. REGISTRAR'S SIGNATURE Charles L. Hume			

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CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY						c. LENGTH OF STAY IN 1b LIFE					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2910 Scherer Ave						d. STREET ADDRESS 2910 Scherer					
3. NAME OF DECEASED (Type or print) DIANA LYNN STIPA						4. DATE OF DEATH May 28, 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 19 1962		9. AGE (In years last birthday) 3		IF UNDER 1 YEAR 3 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas F. STIPA						14. MOTHER'S MAIDEN NAME BARBARA YANISH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. —					
17. INFORMANT Thomas F. STIPA						Address 2910 Scherer Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis 924.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mechanical asphyxia due to plastic cover on a car bed (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interstitial Pneumonitis											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Found face down with head in corner of plastic car crib					
20c. TIME OF INJURY Found Month, Day, Year May 28, 1962 Hour 7:30 p.m.						20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) 2910 Scherer Ave. Balto. 34, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Howard G. Shaub						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county) May 29, 1962					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 31, 1962		22c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL		22d. LOCATION (City, town, or country) Baltimore Md					
23. FUNERAL DIRECTOR CHAR. F. EVANS + Son						24a. REC'D BY REGISTRAR JUN 1 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05572											
CERTIFICATE OF DEATH											
05567											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN lb <u>8 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>701 Cathedral Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>(MARY) Alice</u> First <u>Mary</u> Middle <u>Stuart</u> Last <u>Stuart</u>						4. DATE OF DEATH <u>May 1 1962</u> Month <u>May</u> Day <u>1</u> Year <u>1962</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/1878</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stuart</u>						14. MOTHER'S MAIDEN NAME <u>Louise Schuster</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>217018949A</u>		17. INFORMANT <u>Admission Records</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ASCVD</u> (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 5-1 1962</u> , 19 <u>60</u> , to <u>May 1 1962</u> that (I) (we) last saw the deceased alive on <u>5-1 1962</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert J. Mahon M.D.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>						22d. ADDRESS <u>602 E. Joppa Rd. Towson 4, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<u>BURIAL</u>		<u>5/3/62</u>		<u>LOUNTON PARK</u>				<u>BALTIMORE MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>A J Ruck 5305 HANFORD Road</u> ADDRESS						25a. REC'D BY REGISTRAR <u>MAY 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05573		05568	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1700 William Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary A. Suit		4. DATE OF DEATH Month May Day 22 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Strotman		14. MOTHER'S MAIDEN NAME Mary Vondermohlen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 10 19 62 to May 22 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 22 19 62 and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler, M.D.		22b. DATE SIGNED 5-22-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville, 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/25/62	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City, town or county) (State) Baltimore
24. FUNERAL DIRECTOR'S SIGNATURE Mc Cully Funeral Home		25a. REC'D BY REGISTRAR MAY 24 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Louison</u>		c. LENGTH OF STAY in lb <u>32 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women's & Aged Men's Home</u>		d. STREET ADDRESS <u>43 Bloomsbury Ave Balto 28</u>	
3. NAME OF DECEASED (Type or print) <u>William Shadrack Sullivan</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 13-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - gardner - Carstaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm. S. Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Wilcox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-32-4982</u>	
17. ADDRESS <u>St Louis Sherman 615 Chestnut Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic heart disease</u> (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1956 to May 8, 1962</u> ; that (I) (we) last saw the deceased alive on <u>May 8, 1962</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>May 9, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>WITZKE, 4101 EDMONDSON AVE</u>		22d. ADDRESS <u>4-E-33rd St Balto 18 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/11/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMT.</u>	23d. LOCATION (City, town or county) (State) <u>ELICOTT CITY, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, 4101 EDMONDSON AVE</u>		25a. REC'D BY REGISTRAR <u>May 11 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05575

05570

1. PLACE OF DEATH e. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Westminster c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster, Md 21272 d. STREET ADDRESS 17 Charles St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Arthur Summers		4. DATE OF DEATH Month Day Year 5 26 1962	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Summers	8. DATE OF BIRTH 1-29-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (County & State, or foreign country) Fredricks, Md.
13. FATHER'S NAME Thomas Summers		14. MOTHER'S MAIDEN NAME Anna Digo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-14-872	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Carcinoma of esophagus DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4th		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-11 , 1962 to 5-26 , 1962 that (I) (we) last saw the deceased alive on 5-26 , 1962 , and that death occurred at 12:00 AM on the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer M.D.		22b. DATE SIGNED 5-26-62	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/30/62	23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery	23d. LOCATION (City, town or county) (State) Rural New Windsor, Md
24. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr., Westminster, Md		25a. REC'D BY REGISTRAR DATE MAY 31 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05571

CERTIFICATE OF DEATH

Reg. Dist. No.

05576

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home 329 Harlem Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle Last SUSMAK		4. DATE OF DEATH Month MAY Day 8 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1869
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) laborer		10b. KIND OF BUSINESS OR INDUSTRY various jobs	11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? unknown		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 217-18-3140A		17. INFORMANT Address Caton Ridge Nursing Home, 329 Harlem Ave, Zone 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac failure DUE TO (c) Arteriosclerosis generalis			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 31, 1960 , to 5/8, 1962 ; that I last saw the deceased alive on 5/7, 1962 , and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore DATE SIGNED 5/9/62			
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.		PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr., M.D. 4605 Edmondson Avenue, Baltimore 29	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-11-62	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2		24a. REC'D BY REGISTRAR MAY 10 '62 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Piana			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1925</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1948</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. DATE OF DEATH <i>Dec 10 1970</i>		14. TIME OF DEATH <i>10:00 AM</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
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51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05577		Items 8 & 9 Film 9313 5/16/62 ink		05572	
1. PLACE OF DEATH e. COUNTY <u>BALTO.</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LIBERTY COURT REHABILITATION CENTER</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>5410 LYNVIEW AVE</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First Middle Last <u>JOSEPH SWEREN</u>		4. DATE OF DEATH <u>MAY 14 1962</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 15, 1887</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ISAAC</u>	
14. MOTHER'S MAIDEN NAME <u>REBECCA</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>BERNARD SWEREN, 5513 PRICE AVE.</u>	
17. INFORMANT <u>BERNARD SWEREN, 5513 PRICE AVE.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral arteriosclerotic disease</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>syn</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1942</u> to <u>1974</u> , that (I) (we) last saw the deceased alive on <u>11/30/42</u> , and that death occurred on <u>5/14/62</u> at <u>11:30 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Barclay B. Kins</u> M.D.	
22b. DATE <u>5/14/62</u>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Medale</u>	
23d. LOCATION (City, town or county) (State) <u>BALTO.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>JACK LEWIS, INC.</u> ADDRESS <u>2100 Eutaw Place</u>		25a. REC'D BY REGISTRAR <u>MAY 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05578
CERTIFICATE OF DEATH
05573

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 417 Overbrook Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 417 Overbrook Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DOMENIC TASCA		4. DATE OF DEATH Month Day Year May 24 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 31, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-tailor		10b. KIND OF BUSINESS OR INDUSTRY Hartz-Bank	9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Tasca		14. MOTHER'S MAIDEN NAME Maria	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		17. INFORMANT Address Rena Webster, dght. above	
16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416 X DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Rheumatic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 5 1957 to May 24 1962 , that (I) (we) last saw the deceased alive on May 24 1962 and that death occurred at 6 PM , from the causes and on the date stated above.			
22e. SIGNATURE Arthur S. Hanes		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/26/62
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF 5/28/62	23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS Funeral Home 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE MAY 29 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

Entomologist 5/28/02
Charles E. Schinckel
3331 Stearns Lane

Charles E. Schinckel

Lorraine Hanselman

Baltimore, Md.

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Joseph Tascia

Harris

Harris-Bank

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male white x

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417 Overbrook Road

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Baltimore

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05579

CERTIFICATE OF DEATH

05574

Item 9 Film G312 5/11/62 mh

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in 1b <u>4mth 28dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hynes</u> Middle <u>Terry</u> Last <u>Terry</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 62</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>02</u> Days <u>X</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>guide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>White House</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, severe; etiology unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 18, 1961</u> , to <u>May 2, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 2, 1962</u> , and that death occurred at <u>10:45 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u>		22b. DATE SIGNED <u>5-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMEMIAL (Specify)	23b. DATE THEREOF <u>5/7/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL.</u>	23d. LOCATION (City, town or county) (State) <u>ARLINGTON VA.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc.</u>		25. REC'D BY REGISTRAR <u>1400 Chylin St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>		25c. DATE <u>MAY 7 '62</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05580

05575

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>		c. LENGTH OF STAY in 1b <u>42 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>45 Kinship Road</u>				d. STREET ADDRESS <u>45 Kinship Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTINA +++ THATCHER</u>				4. DATE OF DEATH Month Day Year <u>May 25th, 1962</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 1881</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Duegald Cowan</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-01-0702A</u>		17. INFORMANT <u>Harry A. Thatcher</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1) A-S-C-V Disease</u> <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>senility</u> DUE TO (c) <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-17-62</u> to <u>5-25-62</u> ; that (I) (we) last saw the deceased alive on <u>5-17-62</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>M.B. Davis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Melvin B. Davis, M.D.</u>				22d. ADDRESS <u>Dundalk 22, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc., Dundalk 22, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 28 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William L. House</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 97 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 02 x 02			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS R.D. # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Elsworth Thomas				4. DATE OF DEATH 5 22 19 62		5. SEX M 6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/4/1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Franklin Thomas				14. MOTHER'S MAIDEN NAME Margaret Framilion			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-01-9721		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Disease						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/14 1962 to 5/22 1962, that (I) (we) last saw the deceased alive on 5/22 1962 and that death occurred 5:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 5/22/62		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent	
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				22e. REC'D BY REGISTRAR MAY 25 '62			
22f. REGISTRAR'S SIGNATURE Arthur S. Thane				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 5/25/62				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			
23d. LOCATION (City, town or county) (State) Balto Md.				24 FUNERAL DIRECTOR'S SIGNATURE McCully			
24b. ADDRESS 130 E Fort Ave Balto 30 Md.				24c. DATE MAY 25 '62			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05582

05577

1. PLACE OF DEATH e. COUNTY Baltimore County f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland g. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3736 Elm Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT ANTHONY THOMPSON				4. DATE OF DEATH Month 5 Day 29 Year 1962			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9.3.1907	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Technician				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ROBERT T. THOMPSON				14. MOTHER'S MAIDEN NAME MARY BIBELHAUSER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 216-12-7522			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO (b) 10 years Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 002.1 DUE TO (c) Anteriosclerotic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 10:00 e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5.11.1962 to 5.29.1962 that (I) (we) last saw the deceased alive on 5.29.1962, and that death occurred at 10:00 from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer, M.D., Superintendent				22b. DATE 5.29.62			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6-1-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2				25a. REC'D BY REGISTRAR 1 '62		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After completion of this certificate, the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ROBERT T. THOMPSON

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1902-1903

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05583

05578

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 3 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS Box 475, York Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS ARCHIBALD THOMPSON		4. DATE OF DEATH Month 5 Day 1 Year 1962	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-14-1928	
9. AGE (In years lost birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore County	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOE THOMPSON		14. MOTHER'S MAIDEN NAME (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 212-26-6475	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Far advanced pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH over 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-10-1962 to 5-1-1962 that (I) (we) last saw the deceased alive on 5-1-1962 and that death occurred at 12:20 from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 5-1-1962	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital Mt. Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-1962	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City, town, or county) (State) Towson Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc. York Rd. Towson Md.		25a. REC'D BY REGISTRAR MAY 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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(A)

JOE THOMPSON

(3)

THOMAS J. THOMPSON
2-18-1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05584 CERTIFICATE OF DEATH 05579

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 105 Woodland Ave.				d. STREET ADDRESS 105 Woodland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Istvan Tizer				4. DATE OF DEATH Month May Day 24 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1887		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Galvanizer		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Tizer				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. 213-09-2983		17. INFORMANT Paul Tizer 39 Mavista Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 443X DUE TO Hypertensive-cardio-vascular Disease Dremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 6 weeks.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 7, 1962 to May 24, 1962 , that (I) (we) last saw the deceased alive on May 23, 1962 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE David H. Andrew M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 28, 1962	
22c. PHYSICIAN'S NAME (Type) David H. Andrew				22d. ADDRESS 33 Dundalk Ave Dundalk Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/62		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Colgate, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

43218

CELESTIAL DEPT.

1222



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>625 COLERAINE RD</u>				1. d. STREET ADDRESS <u>625 COLERAINE RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ABBY (ELIZABETH) TRIPLETT</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1866</u>		9. AGE (In years last birthday) <u>96</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>JOHN GREEN</u>				14. MOTHER'S MAIDEN NAME <u>? MARSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MARIE TRIPLETT 625 COLERAINE RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Coma</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CVA + Atherosclerosis</u> DUE TO (c) <u>CVA 8 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>62</u> to <u>May</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>May 29</u> , 19 <u>62</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmondson Ave</u> DATE SIGNED <u>5/31/62</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.				DATE SIGNED <u>5/31/62</u>			
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>				DATE SIGNED <u>5/31/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 1, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>DOGWOOD RD. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edward J. Mether 5311 EDMONDSON AVE</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
JAN 10 1921		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. H. HARRIS	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
10:00 AM		Carpenter		High School		Roman Catholic		Married		1895	
PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT		COUNTRY OF INTERMENT		DATE OF INTERMENT		PLACE OF INTERMENT	
CATHOLIC CHURCH		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		JAN 12 1921		CATHOLIC CHURCH	
NAME OF FUNERAL HOME		CITY OF FUNERAL HOME		STATE OF FUNERAL HOME		COUNTRY OF FUNERAL HOME		DATE OF FUNERAL HOME		PLACE OF FUNERAL HOME	
JAMES H. HARRIS		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		JAN 12 1921		CATHOLIC CHURCH	

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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW YORK. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF PENNSYLVANIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MINNESOTA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WISCONSIN. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IOWA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEVADA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MONTANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WYOMING. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW MEXICO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEVADA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MONTANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WYOMING. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW MEXICO.

1
FOR STATE
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any way is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05586 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05581

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 44 Henderson Road				d. STREET ADDRESS 44 Henderson Road			
3. NAME OF DECEASED (Type or print) Wilma G. Vance				4. DATE OF DEATH May 11, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1922	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ullery				14. MOTHER'S MAIDEN NAME Irene Rhodes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-16-5580		17. INFORMANT Clarence Vance Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 min	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE JACK COLLINS				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/62		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or country) (State) Anne Arundel, Co., Md.	
23. FUNERAL DIRECTOR James E. Bruzdinski				24a. REC'D BY REGISTRAR DATE MAY 14 '62			
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna							

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Handwritten notes and stamps, including "MAY 20, 1962" and "JANUARY".

Handwritten signature or name

Handwritten signature or name

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05587 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05582

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b in transit			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reisterstown Rd. nr. Gwynnbrook Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Bruce Walk				4. DATE OF DEATH Month May Day 28 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1946	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 15 Days 15	IF UNDER 24 HRS. Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John George Walk				14. MOTHER'S MAIDEN NAME Flora Virginia Beck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give year or dates of service) None		17. INFORMANT Address Mrs. John Walk, 6 Byway Rd., Owings Mills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture of skull, left 812 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased walked into side of car transport trailer.					
20c. TIME OF INJURY Hour 4:30 p.m. Month, Day, Year May 28, 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Reisterstown Rd.		20f. (City or town) Owings Mills		20g. (County) Balto.	
20h. (State) Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED May 29, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1962		22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town, or country) Finksburg, Carroll Co., Md.	
23. FUNERAL DIRECTOR Henry James Eckhardt, Owings Mills, Md.				24a. REC'D BY REGISTRAR MAY 31 '62			
				24b. REGISTRAR'S SIGNATURE Charles S. Hantz			

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

Very truly yours,
John A. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film 0311 6/1/62

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b PARADISE NURSING HOME d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PARADISE NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Congress Hotel PARADISE NURSING HOME e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WALL		4. DATE OF DEATH MAY 17, 1962	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 6, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILE SETTER		10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (County & State, or foreign country) MD.
13. FATHER'S NAME EDWARD WALL		14. MOTHER'S MAIDEN NAME CORNELIA MACHEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-14-2238	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate with metastasis to the spine and brain Conditions, if any, which gave rise to immediate cause (b) 177X (c) 177X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 177X		17. INFORMANT Address MRS ROBERT WACKER SR. (NIECE) 5523 FOREST PARK AVE, CATONSVILLE 28, MD.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 62 to 5/17 , 19 62 that (I) was last saw the deceased live on 5/17 , 19 62 , and that death occurred at 3:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. E. McGrath, M.D.		22b. DATE SIGNED 5/18/62	
22c. PHYSICIAN'S NAME (Type) Wm. E. McGrath, M.D.		22d. ADDRESS 1303 Frederick Rd. Balto. 28	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/21/62	23c. NAME OF CEMETERY OR CREMATORY LOUDON PK. CEMT.	23d. LOCATION (City, town or county) (State) BALTO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR MAY 21 '62 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Frame	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

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CHARLES

MR. W. X

THE LATTER

EDWARD BLANK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05589 CERTIFICATE OF DEATH 05584

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>		d. STREET ADDRESS <u>16th + Newton St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie Warner</u>		4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Henry Bond</u>		14. MOTHER'S MAIDEN NAME <u>Laura Warner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Belle R.N.</u>		Address <u>College Manor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>yr -</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on <u>5/27/62</u> 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest C Brown Jr</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr., M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>550 North Broadway, Baltimore 5, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>5-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Towson 4</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 31 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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1953

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250 North Broadway, Baltimore, Md.

Ernest C. Brown, Jr., M.D.

1953

Green House

2-11-53

1953

Dr. E. C. Brown, Jr., 250 North Broadway, Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05585

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 41 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE City d. STREET ADDRESS 3615 SPALDING AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) THEODORE ANTHONY WATTS				4. DATE OF DEATH Month MAY Day 16 Year 1962							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 28 1914		9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS.: Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY STREET LIGHTING				11. BIRTHPLACE (County & State, or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS WATTS				14. MOTHER'S MAIDEN NAME ISABELLE DONNELLY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 212-12-6817		17. INFORMANT Address Hospital Records, Mt. Wilson St. Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 6 Mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from 4/5 1962 to 5/16 1962 that (I) (we) last saw the deceased alive on 5/16 1962 and that death occurred at 10:57 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Wm. Newcomer				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				22b. DATE SIGNED 5/16/62			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 19-62			
23c. NAME OF CEMETERY OR CREMATORY Cathedral				23d. LOCATION (City, town or county) Balto-29-5nd				23e. REC'D BY REGISTRAR MAY 17 1962			
24. FUNERAL DIRECTOR'S SIGNATURE Stewart Horvath				25a. REGISTRAR'S SIGNATURE Stewart Horvath				25b. REGISTRAR'S SIGNATURE Stewart Horvath			

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 7/61

VR A15 (4)
15M 7/61

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MEDICAL CERTIFICATION

122

05591

05586

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if residence after admission) e. STATE	
Baltimore		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Dundalk		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
A-22, Dunleer Apts.		Dundalk	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
A-22, Dunleer Apts.			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
ANNIE E. WEBB		May 17 1962	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		July 27, 1893	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
68 yrs.		Months Days	
		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
At home			
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert Bull		Charlotte Chalk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
No.			
17. INFORMANT		Address	
Mrs. Robt. Purgavie		3011 Dunmurry Road-22	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		5 yrs.	
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) A-C-V-Disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour e.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 16, 1962, to May 17, 1962, that (I) (we) last saw the deceased alive on May 17, 1962, and that death occurred 6:00 p.m. from the causes and on the date stated above			
22a. SIGNATURE		22b. DATE SIGNED	
M.B. Davis			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
M.B. Davis, M.D.		6800 Monrovia Int-Dundalk-22	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		5/21/62	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Oak Lawn Cemetery		Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Ullrich Funeral Home		DATE MAY 22 '62	
Dundalk, Md.		25b. REGISTRAR'S SIGNATURE	
		Arthur L. Harris	

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0531

TESTIMONY OF DEATH

0531

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05592

05587

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Since July 22, 1938		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Hollywood Rural St. Mary's County	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Weiner Last Weiner				4. DATE OF DEATH Month May Day 11 Year 1962			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1/8/94	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 11	IF UNDER 24 HRS. Hours 11 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Blumberg				14. MOTHER'S MAIDEN NAME Rose Narun			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Spring Grove State Hospital - Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) (c) Arteriosclerotic cardiovascular disease (e), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (M) (this hospital) attended the deceased from July 22, 1938 , to May 11, 1962 , that (I) (we) last saw the deceased alive on May 11, 1962 , and that death occurred at 12:02 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Mario Mendoza M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/11/62	
22c. PHYSICIAN'S NAME (Type) Mario Mendoza M.D.				22d. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/62		23c. NAME OF CEMETERY OR CREMATORY Beth Isaac Adas Israel		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. 6010 Reisterstown Road				25a. REC'D BY REGISTRAR MAY 14 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05593

05588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines Nur Home</i>		e. STREET ADDRESS <i>215 Rosewood Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Marie</i> Middle <i>Saxton</i> Last <i>White</i>		4. DATE OF DEATH Month <i>May</i> Day <i>19</i> Year <i>1962</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 16, 1881</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William H. Saxton</i>		14. MOTHER'S MAIDEN NAME <i>Mary Armour Jenkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT Address <i>Mrs Mary S. Ewalt 215 Rosewood Ave. Z#28</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 28</i> , 19 <i>60</i> , to <i>May 19</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>May 19</i> , 19 <i>62</i> , and that death occurred at <i>2:40 P. M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John A. Nesbitt Jr.</i> M.D. <i>1418 St Paul St.</i>		DATE SIGNED <i>5-21-62</i>	
PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT JR</i>		<i>Baltimore 2, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 22, 1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Baltimore St.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 23 '62</i>	
24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05594

CERTIFICATE OF DEATH

05589

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 29yrlmth2lds d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore g. STREET ADDRESS 2303 Allendale Road h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Myrtle Middle Wilcox Last on			4. DATE OF DEATH Month May Day 20 Year 1962		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 8, 1876		9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer		13. KIND OF BUSINESS OR INDUSTRY unknown	
14. BIRTHPLACE (County & State, or foreign country) Maryland		15. CITIZEN OF WHAT COUNTRY? U. S.		16. FATHER'S NAME D. C. Wilcox on	
17. MOTHER'S MAIDEN NAME Elizabeth Hughes		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		19. SOCIAL SECURITY NO. unknown	
20. INFORMANT Records: SPRING GROVE STATE HOSPITAL		21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO 493 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		22. INTERVAL BETWEEN ONSET AND DEATH	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		25. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		27. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
29. (City or town)		30. (County)		31. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 27, 1933 to May 20, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 20, 1962 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.					
22. SIGNATURE Stella Wachsler M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5-21-62		23. DATE SIGNED	
24. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		25. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		26. LOCATION (City, town or county) (State)	
27. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		28. DATE THEREOF 5-24-62		29. NAME OF CEMETERY OR CREMATORY Green Mount	
30. LOCATION (City, town or county) Baltimore		31. (State)		32. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2	
33. ADDRESS		34. REC'D BY REGISTRAR MAY 24 '62		35. REGISTRAR'S SIGNATURE Charles S. Thomas	

10554

10554



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05595

CERTIFICATE OF DEATH

05590

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 12</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 12</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>212 Dunkirk Road</u>				d. STREET ADDRESS <u>212 Dunkirk Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>Theobald</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1962</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1870</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Dr. Samuel Theobald</u>				14. MOTHER'S MAIDEN NAME <u>Caroline DeWolf</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Caroline Pennington</u>			Address <u>305 Regester Ave.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.V.A.</u> <u>331X</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>58</u> to <u>May</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>March 1962</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. K.A. Peter van Berkum</u>				22d. ADDRESS <u>100 W. University Pkwy., Balto., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co. 4905 York Rd., Balto. 12</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

VR A15 (4)
15M 9/60

02:50

02:50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05591

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN It 52 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 300 N. Culver Street	
3. NAME OF DECEASED (Type or print) Edward J. Williams		4. DATE OF DEATH May 17 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1920
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 17 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Cab Company	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar Williams		14. MOTHER'S MAIDEN NAME Josephine Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-05-7586	
17. INFORMANT Clinical Records, VA Hospital, Fort Howard, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction, Recurrent DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Pulmonary Vein Thromboses DUE TO (c) Rheumatic Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26 , 19 62 , to May 18 , 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 18 , 19 62 , and that death occurred at 11:20AM from the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman		22b. DATE SIGNED 5/18/62	
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M. D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-21-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat Cem		23d. LOCATION (City, town or county) (State) Baltimore MD	
24. FUNERAL DIRECTOR'S SIGNATURE Clay O. Wilson		25a. REC'D BY REGISTRAR May 24 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

100

212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05597

CERTIFICATE OF DEATH

05592

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2120 SunBriar Ave.,</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>2120 SunBriar Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Williamson</u> First Middle Last 4. DATE OF DEATH <u>May 26, 1962</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Apr. 10, 1874</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>88 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitation Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Williamson</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Lacy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>219-28-9049</u> 17. INFORMANT <u>Wm. E. Williamson</u> Address <u>2015 Kernan Drive</u>				18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral Vase Accident</u> <u>331X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchopneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/14, 1961</u> to <u>5/26, 1962</u> , that (I) (we) last saw the deceased alive on <u>5/26, 1962</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Max J. Miller</u> 22b. DATE <u>5/28/62</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Max J. Miller</u> 22d. ADDRESS <u>1037 Ingleside Ave.,</u>				22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-30-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Strong</u> 24b. ADDRESS <u>3707 N. North Ave</u>				25a. DATE <u>MAY 29 '62</u> 25b. REGISTRAR'S SIGNATURE <u>G. Howard Strong</u>			

9236

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CONCLUSION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05538

05593

1. PLACE OF DEATH a. COUNTY <u>BALTO. COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5539 BALTIMORE NATIONAL PIKE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OMAR R WILLING</u>		4. DATE OF DEATH Month Day Year <u>MAY 23 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 19, 1882</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOTOR MAN</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY WILLING</u>	
14. MOTHER'S MAIDEN NAME <u>MARY BROWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>216-07-0216</u>		17. INFORMANT Address <u>ROSE WILLING 5539 BALTO. NAT'L PIKE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Diabetes Mellitus ; Mesenteric Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1962</u> to <u>May 23, 1962</u> , that I last saw the deceased alive on <u>May 23, 1962</u> , and that death occurred at <u>11:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Mellow Hill Ave., Baltimore 29, Md</u> <u>5/23/62</u>			
ACTUAL SIGNATURE <u>Leo J. Gavor</u>		PHYSICIAN'S NAME (Type) <u>Leo J. Gavor, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 26, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELLICOTT CITY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WEBER FUNERAL HOME 5311 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-5-39		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION Minister of the Gospel		8. MARITAL STATUS Single		9. EDUCATION High School	
10. RELIGION Methodist		11. PLACE OF DEATH Memphis, Tennessee		12. DATE OF DEATH 4-4-68	
13. TIME OF DEATH 10:00 AM		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF STATE ATTORNEY	
22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF HEALTH COMMISSIONER		24. SIGNATURE OF DEPARTMENT OF HEALTH	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05599
05594

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In The Pines Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights d. STREET ADDRESS 1013 Hammonds Ferry Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANKIE First Middle Last WILSON		4. DATE OF DEATH May 11 19 62 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30th Jan. 1890 Yrs. Months Days Hours Min.
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney - At - Law		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) Birmingham, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edmond Dismukes		14. MOTHER'S MAIDEN NAME Georgia T. Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212 22 5524	
17. INFORMANT Mr. Walton Wilson		Address 1017 Hammonds Ferry Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Chr. Hypertensive Cardio-Vascular Disease DUE TO (c) Chr. Asthmatic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 1 da. 5 yr. 3 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-13-1962 to 5-11-1962 that (I) (we) last saw the deceased alive on 5-11-1962 and that death occurred at 7:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher M.D.		22b. DATE SIGNED 5-11-62	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		22d. ADDRESS 6209 Frederick Rd, Balt-28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 15th May 1962	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		25a. REC'D BY REGISTRAR DATE MAY 15 '62	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

0100

(M)

1000

x

x

Mr. Robert L. ...
Mr. ...
Mr. ...

2-11-68

2-13-68

William K. ...

William K. ...

William K. ...

Glenn Barnes, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Overlea</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4513 Fullerton Ave.</u>					d. STREET ADDRESS <u>4513 Fullerton Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>T.</u> Last <u>Wohrna</u>					4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>19 62</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29 - 1879</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>(Unknown)</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT Address <u>Edward J. Wohrna 705 N. Patterson Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X CVA -- Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>turn</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>at hip injury 10 days</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 57</u> , to <u>11 May, 1962</u> , that I last saw the deceased alive on <u>11 May, 19 62</u> , and that death occurred at <u>7450</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2214 E Fayette St zone 31</u> DATE SIGNED <u>11 May 62</u>									
ACTUAL SIGNATURE <u>Jaroslav Hulla M.D.</u>				PHYSICIAN'S NAME (Type) <u>JAROSLAV HULLA M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5-15-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Puck, Inc.</u> ADDRESS <u>5305 HANFORD Rd.</u>						24a. REC'D BY REGISTRAR <u>15 62</u> DATE <u>MAY 15 62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05601

05596

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> g. STREET ADDRESS <u>1904 Wilmington Ave. - 30</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHESTER L. WOOD</u>		4. DATE OF DEATH <u>May 2 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8, 1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tester</u>	11. BIRTHPLACE (County & State, or foreign country) <u>St. Marys Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Wood</u>	
14. MOTHER'S MAIDEN NAME <u>Mollie Brown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-1</u>	
16. SOCIAL SECURITY NO. <u>217-09-5734</u>		17. INFORMANT <u>Clinical Records, VAH Fort Howard, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>CHRONIC OBSTRUCTIVE EMPHYSEMA</u> 52711 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>April 24, 1962</u> to <u>May 2, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 2, 1962</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VA Hospital, Fort Howard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/4/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 7 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

19

[illegible]

17
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, it should be executed by the Deputy Medical Director. Page 1, 2, and 3 to the Deputy Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Filed 6-11-1962 MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
05602 05597													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY -							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (5)							
c. LENGTH OF STAY IN TB						d. STREET ADDRESS 1048 Lerew Way							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beaver Dam Quarry						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ronald Elwood Workman						4. DATE OF DEATH May 28 19 62							
5. SEX male						6. COLOR OR RACE white							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH May 18, 1941							
9. AGE (In years last birthday) 21 yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator						10b. KIND OF BUSINESS OR INDUSTRY Steel							
11. BIRTHPLACE (State or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Teddy V. Workman						14. MOTHER'S MAIDEN NAME Florence Belcher							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 217-38-1633							
17. INFORMANT Kay B. Workman						Address same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Immediately after eating lunch attempted to swim across quarry. Suddenly went under & stayed under where water is 50+ feet deep.							
20c. TIME OF INJURY Month, Day, Year 5/27 1962 Hour 1:45 p.m.						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Quarry						20f. (City or town) Balto. Md. (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles F. O'Donnell M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) Charles F. O'Donnell						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 5/28/62							
Address (Street, city, town, or county)													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 5/31/62							
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens						22d. LOCATION (City, town, or country) Bel Air, Maryland (State)							
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.						24a. REC'D BY REGISTRAR JUN 4 '62							
24b. REGISTRAR'S SIGNATURE Arthur L. Kline													

VR A15ME
5M 1/62

10-1-5

10-1-5



May 28 1952

Ronald Edward Howard

1018 8th Ave NW

Seattle, Wash

1018 8th Ave NW

1018 8th Ave NW

1018 8th Ave NW

1018 8th Ave NW

Charles F. Dammell

2/8/52

1018 8th Ave NW, Seattle, Wash 98107

**FOR STATE
HEALTH DEPT.**

05603

**MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05598

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14			
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 3005 Glenmore Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Coolidge Ave. Violetsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter		First H. Middle Wornell		Last		4. DATE OF DEATH May 22 1962	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 14, 1899	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plummer				10b. KIND OF BUSINESS OR INDUSTRY Construction Work		11. BIRTHPLACE (State or foreign country) New York, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Wornell				14. MOTHER'S MAIDEN NAME Lena Glaser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 068-10-5357		17. INFORMANT Leonia Wornell Address 3005 Glenmore Ave. Zone 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO 420.1 (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Geo. S.M. Kieffer		M.D. Geo. S.M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S.M. Kieffer		M.D. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 22, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-24-62		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or country) (State) Staten Island, New York	
23. FUNERAL DIRECTOR Wm. Cook-Blight, Inc., 6009 Harford Road, Baltimore				24a. REC'D BY REGISTRAR MAY 24 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05604
05599
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>69yrs. Meredith Rd.</u>		d. STREET ADDRESS <u>Meredith Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Leonard Ephriam Wright</u>		4. DATE OF DEATH <u>May 7 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1 1893</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Wright</u>		14. MOTHER'S MAIDEN NAME <u>Rose Edie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-5565</u>	
17. INFORMANT <u>Mrs. Cora Eva Wright, White Hall, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42010</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> (c) <u>Ca of prostate gland.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>May 1 1962</u> , that (I) (we) last saw the deceased alive on <u>May 1 1962</u> , and that death occurred <u>11:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William O Fulton</u> M.D.		22b. DATE SIGNED <u>5-9-62</u>	
22c. PHYSICIAN'S NAME <u>William O Fulton</u>		22d. ADDRESS <u>Stewartstown, Pa</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Buried May 10, 1962</u>		<u>West Liberty Cem. White Hall, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>May 14 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

02502

02502

(M)

Maryland
Royal-White Hall
Meredith Rd

Feb 1983
W. W.
Mechanics
Construction White Hall Md

Henry Wright
Rose Edge
across the road
Construction

Construction

James
White Hall
West Liberty Co. White Hall Md
Construction